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Preceptorship via Action Research: a Reflective Account
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Alison Morton-Cooper, 1997

Summary

This thesis provides a reflective account of the introduction of a provisional model of transitional learning support (known as *preceptorship*) offered to newly qualified nurses via an action research project. 284 nurses took part in the project over a three year period. By a process of collaborative exploration, reflection and problem-solving, preceptor partnerships were established in the workplace in an attempt to uncover and articulate the learning and socialisation processes encountered at the beginning stages of a nurse's career.

Data relating to the model's implementation was collected via eleven different methods, the most data-rich being that of values exploration and clarification using the dialectical technique of 'Socratic Questioning'. The data and relevant literature were then collaboratively analysed and interpreted by co-researchers using the principles of reflective practice. The emerging account of beginning practice in nursing was then synthesised and 'reconstructed' by the primary researcher, drawing on the theoretical and philosophical perspectives of Social Constructionism and Human Ecology.

A practice based theory of preceptorship was developed and empirically tested through the project, and a description and reflective evaluation of the processes involved is provided here. Tentative recommendations are then offered for the future development of preceptorship in the workplace.

LIST OF ABBREVIATIONS

ENB	English National Board for Nursing, Midwifery and Health Visiting
NHS	National Health Service
RHA	Regional Health Authority
RCN	Royal College of Nursing
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

PRECEPTORSHIP VIA ACTION RESEARCH: A REFLECTIVE ACCOUNT

Chapter One

Introduction

With the advent of late 20th century ideologies which seek to establish nursing as an intellectual discipline and as a profession in its own right, new priorities appear to be emerging in the education and development of nurses, not the least of which is finding the means to provide useful exemplars of good practice wherever practice takes place.

The actual practice and clinical learning of new nurses, and the highly structured environment in which they are expected to work and internalise their roles has not, however, received as much attention from researchers as the immediate transition period from student to qualified practitioner (Benner, Tanner & Chesla, 1996).

Until recently, the means and processes by which new nurses acquire the ability to carry out their practice knowledgeably and with competence remained largely unstudied. Fleck and Fyffe have noted, for example, that there is a strong tendency in evaluative studies of nursing education to focus on learner satisfaction and knowledge acquisition alone, rather than any posited relationship between the quality of learning and the quality of care given to patients and clients consequent to that learning (Fleck & Fyffe, 1997). Previous studies have also tended to examine the techniques and values adopted by learners through their initial education. Whilst worthwhile as an activity in itself, this fails to acknowledge what has become evident in a recent far-reaching study on the acquisition of nursing roles, namely, that learning about the staff nurse role really begins *after* rather than before qualification (Maben & Macleod Clark, 1997a, 1997b).

In an effort to provide new nurses with structured and appropriate guidance as to what is expected of the qualified nurse in the workplace here in the researcher's own domicile of the United Kingdom (UK), the lead statutory body, the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) recommended the introduction of a formal support framework in 1993, one aspect of which concerned the implementation of a learning partnership known as *preceptorship*. This required employers to prepare and establish formal learning support partnerships across the workplace with the stated intent of helping newly qualified practitioners, (and those returning to practice after a career break of five years or more), to consolidate existing skills and theoretical knowledge and to develop their practice and interpersonal skills within a supportive and constructive learning and work environment. Each newly qualified member of staff (known as the *preceptee*) was to be supported and assisted for an agreed period of time (usually four months) by an experienced nurse colleague who had received specific instruction and preparation in the role of supporter, hereafter to be described as the *preceptor* (UKCC, 1993).

To date, however, no substantive research studies have been made available as to the efficacy or outcomes of preceptorship for education or clinical practice in the UK. Difficulties concerning the definition and transferability of support roles between educational systems had arisen earlier when attempting to transfer established support concepts from different institutions and countries of origin, notably from the United States of America (USA) and Australia to British health care establishments. In particular, the practical implementation of support roles seemed to have suffered from poor definition and conceptual muddle, and a perceived lack of consensus over their meaning and appropriateness for practice in different care settings and career situations.

Preceptorship as a means for helping new nurses to adjust to and develop their roles as beginning practitioners thus constitutes new and relatively uncharted territory for educationalists and others involved in assisting workplace learning, with little previous experience or evidence available in the literature to guide the implementation and subsequent evaluation of the new support role in practice.

Problems faced by new practitioners

It has been suggested that the problem for neophytes attempting to get to grips with their new roles is the tension which exists between acceptance by their work group as legitimate, safe practitioners and the prospect of alienation within the workplace until the necessary socialization has been achieved (Ewan & White, 1996). Cherniss observed that the new professionals she interviewed began their jobs feeling enthusiastic and committed, "but the real world wasn't what they anticipated: there were unexpected frustrations, and the collegial support they hoped for never came" (Cherniss, 1995:17).

Experiencing the difference between idealized practice as it was taught in college and the gritty reality of practice could, if not appropriately acknowledged and dealt with, lead to practitioners experiencing what Kramer memorably described as "reality shock" (Kramer 1974:137), and a subsequent risk of failure to cope with and manage the work role on a day to day level. Although in the UK policymakers have retained some workplace experience as part of pre-registration preparation in recent years, the issue remains a highly contentious one. At least one major government study (as yet officially unreported) is thought to be "littered with criticisms" regarding the "practical skills illiteracy" of nurses emerging from pre-registration studies in England from 1990 onwards (Scott, 1997:5).

In response to the preceptorship policy recommendation and fears that nurses might not be adequately prepared for the demands made on them in the foreseeable future, service managers working in the (then) present researcher's own workplace of a British acute inner-city National Health Service (NHS) hospital maintained that in order for such formal support systems to be successfully implemented, they needed to be responsive to local opportunities and constraints. Otherwise, it was argued, support frameworks would not be seen to be effective and/or considered of relevance to practitioners in the field.

It was also becoming clear from an earlier review of the available literature that approaches taken by clinical educators towards beginning practice and the acquisition of skills necessary to the work of nursing appeared to be extremely variable, and not informed by any extensive critique of the interpersonal or emotional aspects of learning as experienced by staff in the early stages of their careers (Morton-Cooper, 1992). This seemed strange given nursing's claim to be fundamentally a human activity.

In particular, scant attention has been paid to describing the methodology by which experienced nurse preceptors of new nurses are monitored in the workplace (Allanach, 1988), so that calls for the preceptor role to be clarified in order to allow their function to be clearly understood and supported by employers continue to appear in the nursing literature (e.g. Coates & Gormley, 1997). As Goldenberg *et al* have noted, while there is no dearth of information on preceptorship *programmes*, there are fewer reports of preceptors' experiences of teaching and learning in the workplace, and most of these have a tendency to be descriptive or anecdotal (Goldenberg, Iwasiw & McMaster, 1997:303). It followed therefore that the proposed implementation of preceptorship in the present researcher's workplace could be a valuable source of evidence-based information and experience to others.

If managed properly, a research proposal which afforded both the pragmatic implementation of policy with the systematic appraisal of policy outcomes might not only be of interest and benefit to those involved in health care, but could also be of interest to a number of different disciplines in social science, and not least to the researcher's own field of practice as an educator of adults.

Articulating the Research Problem

It was clear from the beginning that any definition of the 'research problem' would be purely provisional, and thus dependent for its development and direction on those involved in the implementation process. The study needed to be collaborative.

The *research problem* at the beginning of this study therefore consisted of:

- 1) how to plan and introduce preceptorship into the workplace in line with UKCC policy recommendations; and
- 2) how to do so in such a way as to allow for the systematic observation and analysis of the preceptor relationship and its impact on practitioners and their work environment.

As it had potential significance for other nurses and clinical educators attempting to introduce preceptorship to the clinical setting it was hoped from the beginning that it would generate new knowledge concerning the implementation of such learning support partnerships in the workplace. It was also possible that it might help to fill the evident gap in the nursing and health care literature regarding the impact of preceptorship as experienced by participants in the study, and subsequently on those who were in close contact with them, including colleagues and patients.

If so, this would clearly be of interest to health care policymakers, educators and employers as the demand for evidence-led stringent financial and resource management continues to be a major issue within the cost-constrained NHS: the so-called "economic imperative" to policy enactment and development (Lawler,1997:40).

The Politics of Collaboration

Reflecting the interests of clients, funding organisations, professional assessors and the researcher him/herself is one of the key dilemmas of the research process (Cassell & Symon,1994). The difficulties involved in identifying and attempting to resolve 'real-world' problems via systematic enquiry are well documented for the beginning researcher, as is the premise that "much enquiry in the real world is essentially some form of evaluation" (Robson,1993:6) It is also claimed that the wider use of qualitative methods has come about partly by "the persistent requirement in social policy fields to understand complex behaviours, needs, systems and cultures" (Ritchie & Spencer,1994:173).

Decisions regarding the scope and depth of the research and specific work areas to be involved in the proposed study were greatly influenced by policy changes taking place within nursing education and health care provision in October,1992, at the time of registration for the current degree, and by the researcher's then role as a policy adviser in education and employee development within the hospital's department of Nursing Management. There was indeed an urgent requirement at that time to try to understand and gain insight into the complex behaviours, needs, systems and varying cultures evident within an organisation of some 2000 employees, over half of whom were employed as nurses, nursing students and nursing assistants.

Hospital staff were already reeling from the effects of substantive organisational change. As in many institutions subject to government policy directives in England at that time, the workforce was immersed in a complex process of re-organisation concerning staffing, operational management style and management ethos: what Pettigrew *et al* have described as "top-down restructuring" (Pettigrew, Fairlie & McKee, 1992:31).

At the same time, the educational and logistical preparation of nurses and other carers to staff the new market-oriented and market-driven NHS was seen as a priority within the broader governmental game plan. Strategic policy-makers within nursing had already been busy from 1983 onwards reforming nurse training from an apprentice style service-led certificate training programme to a broader-based educational programme provided within the context of higher education, the three year 'Project 2000' Diploma in Higher Education (UKCC, 1986). Controversially this stopped short of the Royal College of Nursing's Commission on Nurse Education's recommendation that all future preparation for nursing should be at graduate level (RCN, 1985, 1997).

The planned evolution to one level of nurse registration where previously there had been two also placed an onus on employers to provide opportunities for staff in post to upgrade their enrolled (second level) nurse qualifications to those of first level (previously State Registered Nurse) in line with UK national policy requirements (UKCC, 1990). The curriculum 'shift' therefore lay in marrying the much vaunted "instrumental" or "competency led" curriculum with "a more predominantly reconstructionist approach to curriculum development and innovation i.e. an approach that centres on the needs of society" (Miles, 1995:30).

Policy changes therefore occurred at both a macro and a micro level within the organisation. First of all at the level of service delivery (in rationalising staff and other resources in line with the hospital's newly devised business plans), and in the expansion or contraction of certain specialist services with regard to the new management board's express remit of care to the local community. Secondly, in terms of employee development, those services which had previously performed poorly in the board's view might expect to be downgraded, relocated or closed, while expansion in other areas required new or specialist staff to be recruited and additional training given as necessary. Where opportunities were limited, redundancy or retraining became the only realistic option for a number of staff, some of whom had seen long service with the organisation.

Working within a team whose task it was to plan, manage and develop a strategic framework for nursing practice, education, management and policy meant that priorities at that time were not always clear, sometimes daunting and always demanding in both emotional and managerial terms. The researcher was conscious of the need to be sensitive to the prevailing climate of disorientation which was affecting the workforce.

The study could, in theory, provide a focus for organisational and interpersonal support for staff undergoing massive organisational flux. However, it could also expose itself to the danger of being seen as a managerial imposition, particularly given the researcher's role in the organisational hierarchy, which in turn might affect the study's credibility and thus its validity as legitimate research. This could be seen to be both the best and the worst of times to invite collaboration. It was therefore incumbent on the researcher not to compromise the study ethically, and to recognise that those staff who had already been rendered vulnerable to a number of different forces should not be further exposed by a research process which might undermine any adaptive abilities they might have for managing change within their constantly evolving work environment.

Added to this were the policy changes confronting higher education as the binary divide between 'old' and 'new' universities responded to a national policy of expansion in post-compulsory and higher education. The wholesale relocation of colleges of nursing and midwifery to university health care faculties, in a process of amalgamation and competitive tendering for their services, also brought political and logistical problems in its wake.

Educators were charged with having to "equip nurses with the critical faculties to discern between good new ideas and new ideas that only sound good but will turn into tomorrow's dogma and ritual" (Ford & Walsh, 1994:87), and so rescue nursing from its low status position in the NHS power structure and its perceived "intellectual and social subordination" (Rafferty, 1996:1)

It has been argued, for example, that until relatively recently nursing has been constructed within a medical paradigm, that is to say that nurses directed their work towards the doctor's rather than the patient's needs (Armstrong, 1983), a legacy which some have interpreted sociologically and stereotypically as the 'handmaiden's role'[sic] (see Glen, Beverley & Coyle, 1996:43). Thus the knowledge base of nursing evolved as a derivative of the more prestigious high ground of medicine which, according to Witz, has subsequently "precluded nurses from negotiating a sphere of cognitive exclusiveness" (Witz, 1992:147). Ironically, in order to pursue higher status through attempts to professionalize, nurses stand accused of supporting "the methods and behaviours employed by the dominant [presumed medical] ideology to gain recognition" (Hendricks-Thomas & Patterson, 1995:595).

From the researcher's own experience, policy 'strangulation' was already a reality within the workplace, with nursing priorities regularly having to compete with other more powerful interests. In planning a research study which would have the ability to cut through the apparent institutional inertia and internal organisational competitiveness, careful thought therefore had to be given to the ways in which the research was to be conducted, and as to how it might be funded, and thus communicated, to the world at large.

Local issues and constraints

The history of nursing and politics has been intertwined with the profession's perception of and value for, itself (Tattam & Thompson, 1992: 110). Criticism has in the past been levelled at nurses for failing to act politically and assertively (Clay, 1987), with nurses preferring traditional generalized and stereotyped analysis of social policy issues which attempt to "problematize" rather than respond critically to important social issues (Gough *et al*, 1995:2).

Where research requires some form of intervention it is important to assess the relative merits of quantitative versus qualitative approaches. It is also important for the researcher to respect the potential costs of implementing research findings in advance of any proposed innovation. Organizational costs may be high; changes in procedures or structures are always a challenge. In any health care setting the different workers have evolved specific working relationships which some groups or individuals may have a vested interest in maintaining (Norr, 1994:112).

In assessing the potential for any proposed study, it is vital to ascertain the likely stakeholders, and to clearly identify those whose interests may be threatened so that the researcher may at least be aware of potential ethical or financial constraints and any obvious political hurdles to be negotiated as part of the research venture. For example, nursing staff who were to be approached for inclusion in the study anecdotally reported the following difficulties in supporting each other through the critical transition from junior to more experienced member of staff:-

- * a mismatch between managers and staff performance expectations
- * low morale and a degree of employee disaffection and 'wastage'
- * ineffective performance review systems
- * poor relationships and value conflicts concerning 'attitudes' and job performance
- * some insularity and defensiveness within work teams
- * ambivalence and indifference regarding the problems of newly qualified staff
- * communication difficulties
- * no apparent baseline or consistent criteria for measuring the performance of new employees
- * an apparent lack of meaningful emotional support for all staff at times of crisis or transfer to an unfamiliar work environment
- * symptoms of reality shock articulated by the newly qualified and new in post
- * flooding of the job market by newly qualified and redeployed nursing staff leading to a freeze on recruitment in some areas with consequent anxiety and low morale amongst nursing students and teaching staff

Staff were also feeling the impact of the introduction of the UK NHS Patients' Charter, (DoH 1991,1995), which sought greater accountability and quantification of objectives and outcomes for the service in answer (at least in part) to a significant increase in the number of litigation cases being brought against health care providers. Any proposed methodology therefore needed to be cognisant of the prevailing political milieu and of the researcher's likely involvement in managing local and cultural change.

Philosophical underpinnings of proposed methodology

Social Constructionism and the Search for Values

Before making any decisions regarding the practicalities of methodology it was important to be clear about the philosophical stance underpinning the proposed work. From the beginning, it has been possible to interpret meaning in relation to preceptorship philosophically inspired by 'social constructionism'. Central to constructionism is the premise that human beings are agents rather than passive organisms or disembodied intellects that process information (Sarbin & Kitsuse,1994). Constructionism therefore develops the idea that "social objects are not given 'in the world, but constructed, negotiated, reformed, fashioned, and organized by human beings in an effort to make sense of happenings in the world" (ibid:3). Discussing the work of Jurgen Habermas, Kemmis describes a critical social science as a species of social theory "which in separate but related ways , aims at:

* ideology critique (criticism of the nature and social relations of production, reproduction and social transformation, including the circumstances and consciousness of people as individuals, members of groups and bearers of culture);

* the organization of enlightenment in social groups and societies (including some kinds of educational process); and

* the organization of social and political action to improve the world (guided by a dialectical notion of rationality, and a communitarian, egalitarian notion of justice and freedom)".
(Kemmis 1995:13)

This philosophical approach to understanding the world seemed to the researcher to be a useful way of exploring and interpreting data, and of attempting to formulate some prospective theory of preceptorship as a transitional learning process.

A similar approach, which could be considered to be pragmatic in nature, found a natural home in the research strategy known as 'Action Research' (McNiff *et al*, 1992, Barton-Cunningham, 1993, Stringer, 1996), and the method of intellectual argument developed by the Greek philosopher Socrates, the Socratic '*elenchus*' or dialogue i.e. 'the Socratic method of eliciting truth by cross-examination' (Shorter Oxford English Dictionary, 1973:639).

Nolan and Grant suggest that an important prerequisite of any action research study in nursing is to establish in advance the basic values which underpin care in a given area. They stress from experience the need to reach early agreement on fundamental issues if substantive changes in practice are to be achieved (Nolan & Grant, 1993:308).

Socratic Method is not to the researcher's knowledge a well documented or recognised research strategy, but it does have a long and distinguished history within moral philosophy as a means of searching out human values, in so far as Socrates has been credited with undertaking the "first sustained treatment of ethical questions" in the fourth century B.C. (Jordan, 1990:60). Socrates is said to have encouraged his students to think critically and to make a virtue of knowledge in the interests of moral conduct (Saunders, 1987).

Thus by drawing on the classical literature it has been possible in the present study to use the dialectical methods of knowledge discovery propounded by Socrates, and to devise a method of critical and analytical groupwork which, when taken together with more contemporary models of focus group technique, combine to form a very useful method of values clarification for those taking part in action research.

The Nature of Action Research

Action research enjoys an established position in educational theory and practice (Chisholm, 1990), although its pedigree in health care research would appear to be relatively recent. At its simplest it has been described as the implementation of change to generate theory (Greenwood, 1994). McNiff *et al*, (1992) have characterised action research as an approach to research, rather than as a particular methodology, and as a way of working which is "practitioner generated; workplace oriented; seeks to improve something; starts from a particular situation; adopts a flexible trial and error approach; accepts that there are no final answers; and aims to validate any claims that it makes by rigorous justification processes" (McNiff, Whitehead & Laidlaw, 1992:3).

The importance attached to human values and the clear workplace orientation of this approach to investigation made striking good sense to the researcher, particularly if we are to accept Leininger's thesis that validity in qualitative research refers to:

"[G]aining knowledge and understanding of the true nature, essence, meaning, attributes and characteristics of a particular phenomenon of the study. Measurement is not the goal...the researcher proceeds to sample until satisfied that the richness of data is accurate and meaningful to report."
(Leininger, cited in Brink & Wood, 1989:177)

In a review of the literature on action research Hart & Bond (1995) identified seven criteria which they claim distinguishes it from other methodologies when used in "dynamic interaction". The criteria are that action research is educative; deals with individuals in social groups; involves a change intervention; aims at improvement and involvement; involves a cyclic process in which research, action and evaluation are intertwined and that it is founded on a research relationship in which those involved are participants in the change process (Hart & Bond, 1995:37-38).

While it could be argued that individually these characteristics could also be used to describe other fieldwork methodologies, it is the dynamic and cyclical interaction of these criteria which is thought to make action research distinctive. The study proposed would therefore place itself halfway between the '*professionalizing*' and '*empowering*' types of action research described by Hart and Bond, by virtue of its emphasis on structural change; the educative need to reflect on practice; the wish to enhance professional control (and the individual's ability to control his or her work situation), while at the same time attempting to shift the prevailing balance of power towards a group of workers which has traditionally been seen as oppressed by others (Hart & Bond, 1995:40, Table 3.1).

A similar approach has been discussed by Holter & Schwarz-Barcott (1993), who say that nurses have the potential to break existing scientific boundaries (and thus, in their view, improve nursing practice) by combining empirical and normative judgements, thereby opening up the possibilities for alternative investigation. The central goals of the "enhancement approach" advocated by these authors are those of aiming to increase the closeness between problems, practice and the theory used to explain and resolve those problems, and the questioning of key assumptions through raising the collective consciousness of practitioners.

Such a study would raise questions about underlying assumptions and values affecting the situation confronting them, and assist practitioners to critically reflect on their practice by "bringing to light the difference between stated practices underlying assumptions and unwritten laws which really govern that practice":

" The researcher facilitates the practitioners' discussion of underlying problems and assumptions on a personal level as well as the level of the organization's culture and the possible conflicts they can generate. The emphasis here is on bringing to the surface the underlying value system, including norms and conflicts which may be at the core of the problems identified. Local theory emerges from reflective discussions between the researcher and the practitioners. Changes are focused on personal and cultural norms and tend to have a lasting character as the negative forces of the organizational unconscious can be dissipated and a meaningful change can be achieved and sustained".

(Holter & Schwarz-Barcott, 1993:302).

Action research therefore had the potential to provide an effective platform for the necessary reflective discussions which would allow the generation of theory from practice.

Support Concepts and the Workplace

In earlier work aimed at evaluating support concepts and policies related to beginning practice in nursing the researcher considered specific policies aimed at alleviating the reality shock experienced by newly qualified staff in their transition to the role of qualified and legally accountable practitioners. Consideration was also given to the emotional and practical support offered to nurses returning to practice after a substantial career break and to those new in post who had already had the benefit of several years' service. This analysis of support concepts and a review of the available literature revealed a distinct lack of rigour in defining support roles, and in preparing experienced staff to enact these roles in day to day nursing practice (Morton-Cooper & Palmer, 1993).

It seemed that support concepts had evolved without any real evidence of analysis and reflection on their impact in the work setting and on the individuals or work teams involved. The rush to import concepts which had successfully been used elsewhere, such as mentoring, followed a trend in popular management theory, but little thought appeared to have gone into its transferability or appropriateness for the clinical setting, and the very close and, paradoxically, conflicting relationships which can develop in such an emotionally intensive setting as patient care.

In order to understand the socialisation processes operating in the workplace it would be necessary to set up, support and maintain a network of preceptors and preceptee partnerships, and to set appropriate boundaries for the critical examination of the nature of the difficulties associated with beginning practice, thus allowing both parties to properly reflect on their responses, actions and reactions to challenges experienced at work. The tools which were found to do this were those of *reflective practice*, the rationale for which is outlined below.

Producing a Reflective Account

The focus on practice and the incorporation of reflection as a learning tool in workplace education is thought to enable learners to solve problems in practice. By exploring their unique situations learners may therefore be encouraged to generate new knowledge (Murphy & Atkins (1994), Schon (1991)).

Schon has pointed to the limitations of the 'technical-rationality' model of professional education, and to the "crisis of legitimacy" rooted in the perceived failure of professionals to live up to their own and society's expectations as a consequence of their dependence on the status of the scientific method. In his view we have increasingly become aware of the importance to actual practice of various phenomena, of complexity, uncertainty, instability, uniqueness and value-conflict, none of which readily fit the model of Technical Rationality he describes. Problem-*solving* is in itself not enough to teach us what it is to be competent or 'professional', rather:

"In real world practice, problems do not present themselves to the practitioner as givens. They must be constructed from the materials of problematic situations which are puzzling, troubling and uncertain. In order to convert a problematic situation to a problem, a practitioner must do a certain kind of work. He must make sense of an uncertain situation that initially makes no sense"

(Schon, 1991:40)

The difficulty for nursing is that unlike the "high hard ground" described by Schon as the place where practitioners can make effective use of research-based theory, nursing in its emotion-laden and sensitive human scenarios tends to resemble his "swampy lowlands", where situations appear to be confusing "messes" incapable of technical solution (Schon, 1991:42). It would therefore seem that Rolfe is right in his assertion that the relationship between theory and reality which has served the hard sciences so well simply doesn't hold water for the theory and practice of nursing. It may have done once, in the days when nurses depended on medicine for its knowledge base. Rolfe is optimistic, however, that there is a solution to this apparent 'theory-practice gap'. It does, however, mean that nursing must be viewed differently:

"...it involves reformulating the concepts of nursing theory and nursing knowledge to make them compatible with contemporary definitions of nursing practice as relationship building and individualised, holistic care.....What is required is a body of theory which describes, explains and predicts the idiosyncrasies of individual encounters between patient and nurse, that is, a theory of practice"

(Rolfe,1996:24)

Reflection is needed to generate what Benner has referred to as a repertoire of paradigm cases which can be drawn upon in future clinical situations, the goal of reflection being not simply to improve practice, but to change the way practice is conceptualised (ibid:192, Benner,1984).

Rolfe, however, insists that such changes in practice must likewise be mediated by changes to our personal knowledge base and thus our shared network of experiences. *Reflection-on-action* then allows us to *reflect-in-action*, as we bring previous experience and knowledge to bear in the situations which confront us. Reflection-on-action is therefore both a research method and an educational process, seeing practitioners as generators of their own knowledge which can then be shared and utilised by others (Rolfe,1996: 102-3).

By using focus groups to reflect on the action brought about by the implementation of the preceptorship policy, it was therefore possible to set the cyclical action research wheel in motion:-

action = reflection on action + reflection in action to produce new knowledge= new action leading to more reflection.....which leads to further action, more reflection and so on....

Opportunities for Building a Theory of Practice

In developing a culturally valid and appropriate method of knowledge acquisition then, such reflective processes need to be made explicit to practitioners. Eraut has pointed out that the work context dominates professional socialization in the formative early years of professional practice (Eraut, 1994:40). The need to harness best practice and to develop positive attitudes to workbased learning is therefore critical to any would-be profession's development. He warns, however, that: "[F]or every work setting that teaches and inspires the next generation of leaders..there are others that limit their development and perpetuate the weaknesses of the previous generation" (ibid:40).

Eraut is also critical of the old distinction between technical and practical knowledge which assumes the former to be used systematically and explicitly while the latter is idiosyncratic and somewhat implicit. Rather, he acknowledges that research into professional practice is beginning to see scope for making practical knowledge more explicit "and thus more capable of being disseminated, criticized, codified and developed" (Eraut, 1994:47). One could perhaps take him to task, however, for attempting to impose the values of technical-rationality on the new ground to which he refers. As Schon has made clear, technical rationality depends on agreement about ends. Where the ends are confused and conflicting there is as yet no 'problem' to solve: thus a conflict of ends cannot be resolved by the techniques of applied research:

"It is rather through the non-technical process of framing the problematic situation that we may organize and clarify both the ends to be achieved and the possible means of achieving them"
(Schon, 1991:41)

On a theoretical level it is therefore possible to see how the discourses and practices of modernity were characterised by an emphasis on progress and a faith in the rationality of science, and why this is now being questioned by postmodern thinking.

Postmodernism challenges old certainties and questions the universal efficacy of technical-instrumental reason, as well as that of the stance of objectivity and value-neutrality in the making of knowledge claims (Usher, Bryant & Johnston, 1997:6/7). By using the tools of reflection to carefully examine existing value systems it is therefore possible to overcome the constraints and limitations of technical rationality. Such openness of approach not only accepts the contested nature of knowledge but also acknowledges "the need for knowledge which is locally grounded and efficacious in relation to local struggles" (ibid:12). The opportunity to develop a socially supportive and educative framework for practice is then made possible by allowing practitioners to reflect on entrenched attitudes and taken-for-granted practices in their world, and to sensitise practitioners to areas of convergence and conflict with respect to personal and collective or 'professional' values.

It has been claimed that nursing is currently undergoing a cultural reconstruction: that the reality of nursing as a discipline *is* 'practice' (Davies & Lynch, 1995: 389-401). Thus the possibilities for building a new paradigm of research around practice theory suggest themselves. Collaboration via action research and Socratic Method may therefore be justified on these grounds.

Figure 1 illustrates the way in which the action research process was able to generate theory from practice. *Figure 2* outlines the beginning research plan which will be discussed in more detail in later chapters.

Figure 1 Theory Generation via Action Research

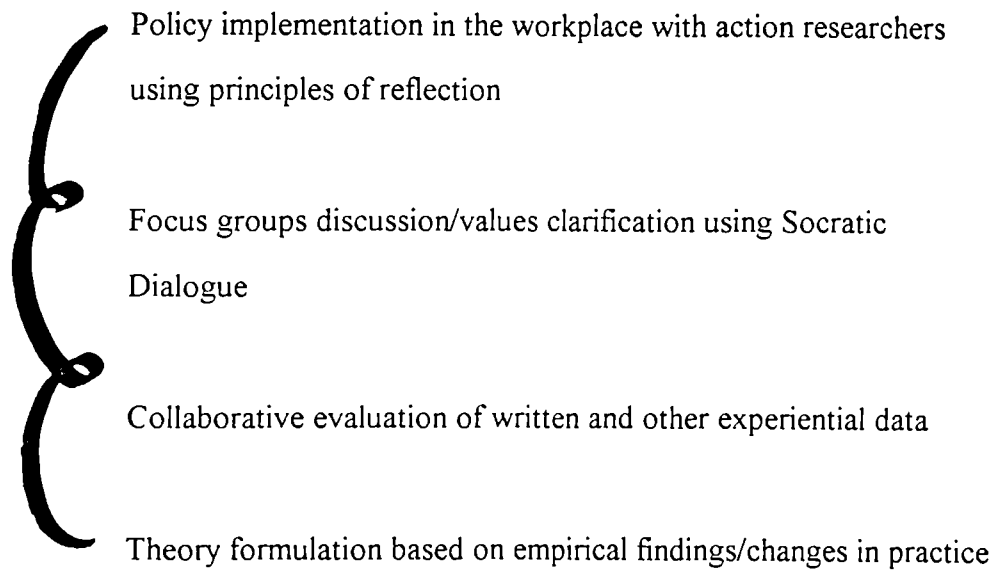


Figure 2 Outline research plan

Research priorities at the beginning of the study included;

1. The setting up of an initial pilot/ Delphi study of staff in order to determine priorities and issues of relevance to preceptorship at that time;
2. Obtaining management approval for access to the four research site/s, together with the drawing up of ethical guidelines and briefing strategies which would inform research practice and all co-researchers involved in the study;
3. The identification and briefing of research facilitators (known as 'Unit Preceptors') for each site involved in the project;
4. The identification and briefing of potential preceptor staff nurses and preceptees;
5. Communication of the study's aims and strategies to others whose work was relevant, especially educators, staff developers, colleagues and clinicians;
6. Preliminary discussion and agreement on the design of working documentation/working definitions to be used by co-researchers;
7. Preparation and briefing of all co-researchers with regard to both policy implementation (*action*), collaborative analysis of emerging data (*reflection on action*), subsequent modifications to practice based on this analysis (*reflection in action*) and the development of theory arising from the study's findings (i.e. *new knowledge leading to new forms of action*).
8. Continued reflection and values clarification regarding issues and decisions central to providing transitional learning support in the workplace using written documents and reflective discussion in focus groups, support meetings and preceptorship practice.

[A full list of both primary and secondary sources of data and techniques used to collect it is given in Chapter Three which examines study design and process management].

The Role of Different Literatures in the Study's Development

Given the collaborative nature of an action research study, the literature review which emerges from the collaborative, reflective and discursive process is necessarily eclectic and has the potential to draw on a wide range of literatures. Within the social constructionist paradigm, objectivity becomes an impossibility, with each of us encountering the world from some perspective or other:

"The task of researchers therefore becomes to acknowledge and even to work with their own intrinsic involvement in the research process and the part that this plays in the results that are produced. Researchers must view the research as necessarily a co-production between themselves and the people they are researching..." (Burr, 1995:160)

Such research - geared towards change and intervention as its explicit aim- is therefore a political activity, constituted by the discourses and frameworks devised by co-researchers to make sense of their experiences in the world (ibid:162).

It is important to note here that the term *co-researchers* is used in this study to refer to all those staff who participated in the implementation of preceptorship over the three year period. They include all practitioners, educators, service managers and senior nurses involved in staff development who took part in (or otherwise contributed to) the introduction, setting up and monitoring of the preceptorship partnerships, as well as those policymakers and administrators whose job it was to oversee policy implementation on a geographically region-wide basis. In the interests of clarity, the term *primary researcher* refers to the research student who took overall responsibility for the good conduct of the study, and for co-ordinating the collaborative action research process as a substantial component of her research degree.

Co-researchers agreed from the beginning of the study to search out articles, books, policy documents and research studies which might have a bearing on, or be of interest to, those involved in implementing preceptorship in the workplace. By sharing in the analysis and synthesis of such reading it was thought that some consensus might emerge as to the appropriate strategies to follow in implementing learning support partnerships with the benefit of insights drawn from previous thinking and research.

The literature review process was intended to provide a forum for discussions, suggest alternative ways of 'seeing' or looking at the issues, and as a means to seek out different explanations of phenomena and experiences in the workplace. It gave co-researchers a concrete task which helped to bring them together as a group from the beginning of the study, and allowed them to share and enrich their mutual knowledge base. Some co-researchers had very little experience of conducting literature searches and were anxious that prospective preceptees would be more adept than they were at using the literature. The opportunity to acquire and develop these practical skills was therefore welcomed, and helped to expand individual as well as collegiate horizons as the group of researchers grew larger and more diverse over the three year period.

It also helped to motivate co-researchers in the hope of finding new approaches to some age-old problems and dilemmas experienced in practice. This meant that the study was 'grounded' more rigorously than it might have been with only the primary researcher being involved in the literature review process.

The different literatures referred to naturally reflected the variety of interests and 'leanings' of the individuals concerned. Over time, the principal literatures consulted included:

- continuing education theory and practice
- management, human resource management and organisation theory
- nursing and health care education and practice
- theories of 'reflection' and 'reflective practice'
- nursing and health care research
- social research and methods texts
- sociology of organisations and gender
- interpersonal, social, occupational and developmental psychology
- social constructionism/poststructuralism
- emotions theory
- human and environmental psychology
- classical texts on Greek philosophy and oratory

Bringing together such a broad range of ideas was an exciting part of the research process, and enabled co-researchers to rise to Worrall-Carter's challenge to develop a "community of scholars" at the interface of nursing practice and research (Worrall-Carter, 1995:69).

The primary researcher's task involved looking for connections and competing explanations for different situations and phenomena arising from the practical implementation of the new support partnerships. What problems were commonly experienced across the cohorts, and what different (or strikingly similar) approaches towards solving these problems emerged? Which literatures enabled co-researchers to conceptualise and analyse their respective situations, and could therefore be developed to provide a theoretical framework for the better understanding of preceptorship and beginning practice in nursing? It soon became clear that the depth and breadth of the literature had to have some guiding themes, and that it would be helpful to find some conceptual frameworks which could be usefully employed across the range of clinical areas involved.

The primary researcher also had to maintain some level of personal control in order to provide a reflective account of the study which adequately described, analysed and synthesised the work conducted on its behalf.

The discipline of 'traditional' psychology provided the greatest amount of work of (apparent) immediate relevance to the study, but its limitations were soon reached as many of the explanations and theoretical constructs used failed to describe or account for the difficulties encountered in providing interpersonal support to beginning practitioners. Instead psychological explanations came to be seen as only one of many powerful 'discourses' for explaining human relationships.

The questions most often asked by co-researchers concerned whether the problems were structural (i.e. lay with the institution and the expectations placed on practitioners by those in positions of relative power), or whether they were the result of resistance to the more influential and dominant discourses of science as enacted in medicine and/or women as carers, so that nurses and nursing are seen as the embodiment of these discourses in maintaining the conditions required for their enactment. If, as Foucault would have it, nursing is *constituted* by its language and social practices, what insights did this offer for helping individual practitioners to bring to their work some sort of agency and 'voice' for themselves? (Foucault, 1973, Gergen, 1989, Turner, 1997). The literature reviewed and decisions made as to what to include or exclude were therefore an important part of our collective social 'construction' of nursing.

The primary researcher's own reading (and philosophical approach) necessarily brought to the study a thematic approach which may, or may not, accord with other co-researchers thoughts and priorities regarding the study. It is only in reflecting on the different roles or parts played by co-researchers that the impact of different contributions is made more explicit, and this is discussed in more detail in later chapters as the nature of our discussions and collaborative work is communicated. Attempting to do justice to a large, multi-site action research project is a complex and demanding task for any researcher. Action research outcomes are usually expressed in the form of a project report, a format which does not lend itself easily to the conventions of academic writing. The seven chapters of this thesis then are presented as a necessarily discursive account of the reflective and reflexive processes involved in marrying both the pragmatics of action research and the requirements of academic rigour.

Thesis structure and content

Chapter One introduced the aims and scope of the project and outlined the problems faced by newly qualified nurses in making the transition from beginner to experienced and accountable practitioner. The research problem was articulated and placed in its clinical, educational and social context. The politics of collaboration were discussed in relation to local issues and constraints likely to impinge on the study. The philosophical underpinnings of the proposed methodology were explored and a justification for the use of reflective practice offered. The process of theory generation via action research was illustrated and an overview of the beginning research plan was provided. The role of different literatures in the study's development was also discussed.

Chapter Two highlights some of the major philosophical issues regarding adult learning and the language used to construct notions of 'emancipation' and 'liberation' in adult learning experience. These are related to the problems of 'postmodernity' posed by contemporary social theorists, educationalists and historians. The chapter then considers the difficulties encountered in trying to establish a disciplinary base for nursing practice, arguing that traditional positivist philosophies do not adequately account for the ways in which nursing knowledge may be acquired. The possibility of 'reframing' nursing's position through social constructionist analysis is then raised as one way of trying to understand and improve the situation of practitioners.

Chapter Three discusses the alternative methodologies considered and demonstrates the thinking behind the decision to opt for a collaborative action research design. It highlights some of the contextual difficulties of arriving at an appropriate methodology. The aims, conduct and outcomes of the pilot study undertaken to establish researcher priorities are described. A summary of the data gathering processes is given together with a list of primary and secondary sources which were used to inform the study at different stages in its development.

Chapter Four introduces the provisional model of transitional learning support devised for use in the study and goes on to show how this was used to implement preceptorship policy in practice settings. A discussion on the use of Socratic Method/experiential workshops to clarify the values and stances of co-researchers as an adjunct to policy implementation is followed by information on the techniques used to code and categorise the data which emerged from both the implementation of preceptorship in clinical areas, and the issues and constructs raised by workshop participants.

Chapter Five replaces the conventional literature review to be found in non-action research studies and offers instead an analysis and synthesis of literature found to be relevant to the study of transitional learning support as it evolved through the action research process. The centrality of emotions to learning processes is the main focus of the chapter, where it is argued that educators have a responsibility to provide adequate social support within learning environments so that emotions (and their human consequences) are not marginalized. Constructs and concepts related to the emotional demands placed on workers are analysed from the perspectives of traditional psychology and that which has been described by the primary researcher as 'human ecology'.

Chapter Six is the most substantial chapter of the thesis. A reflective account of the themes and issues generated by the data is offered via the primary researcher's 'reconstruction' of the discourse of beginning practice in nursing as described and collaboratively analysed by the study's co-researchers. Criteria for effective preceptorship support provision are offered as a beginning 'practice theory' of transitional learning support. Tentative recommendations are also made for the future development of preceptorship based on the outcomes evaluated via action research.

Chapter Seven, the final chapter in the thesis, is an attempt to engage in 'metareflection'. This has been interpreted as the ability to reflect on one's own reflective processes as a researcher and integral part of the research process. As such the chapter describes the ways in which preceptorship theory was developed through the study; examines the role of reflection in theorising (with particular reference to the experience of both primary and co-researchers); discusses the link between theory and method, and, finally, assesses the value of action research as a vehicle for reflection and learning.

Philosophical Concerns

Adult Learning and Social Context

Efforts by adult educators to define what is unique about learning in adulthood continues to engage researchers and practitioners alike (Merriam,1993). Didactic methods of teaching have been criticised for their inadequacy in appealing to the adult learner's presumed sense of autonomy as an individual, and for reducing the learning process to one of passivity to perceived authority, the so-called 'pedagogic' or 'conformist' view of human teaching. This presumes that there is an external reality into which students must fit, arising from the perception that constructive and creative citizens develop from those who are passive learners (Rogers,1986:19).

Abercrombie prophetically warned us of the dangers of this method of adult teaching and learning, in particular when we expect adults to experience and manage change successfully. Referring to the traditional university education of student and lecturer, she described this approach as "an extension of the infantile learning situation, attention being paid to the absorption of information and skills by an individual in contact with the source of that knowledge", similar in her view to the therapeutic relationship aimed at between doctor and patient (Abercrombie, 1968, Nias, 1993:60). Abercrombie felt that adult educators still had much to learn about how to organize learning so that methods could be adapted to suit different educational purposes:

"It is imperative that we learn how to emancipate ourselves from the notion that information comes best from above, to the individual, isolated from the social context. Productive though this situation may be in times of stability, it cannot work effectively in times of rapid change, or produce people who can easily respond to change... Ways of behaving are adopted not only from precept, but mostly unconsciously, by passive absorption from the culture, unquestioned and only partly questionable, because only partly verbalized..."
(ibid: 61)

Although historically adult education has drawn on other disciplines to inform its practice, such as developmental and cognitive psychology, Merriam suggests that three perspectives have received prominence in recent years, thus 'infusing' themselves into the adult education literature. They are *sociology*, *critical theory* and *feminist pedagogy*. In her view, proponents of critical social theory focus on the social context in which adult education and learning take place:

"Their objective, however, is to uncover oppressive forces that hinder individuals from developing their full potential. At the same time, critical theorists are interested in finding ways to empower people individually and collectively to change the oppressive conditions of their lives. The major thrust of critical theory has been to critique the modern practice of adult education. A central criticism is that adult education is preoccupied with technical concerns at the expense of democratic social action" (Merriam, 1993: 11)

One early dilemma for the primary researcher concerned the language and concepts used in the adult and continuing literature. Many appeared to be value-*driven*, owing much to the respective intellectual traditions of influential social thinkers such as August Comte, Max Weber, Emile Durkheim, Karl Marx and Jurgen Habermas.

The observation of the French philosopher Rousseau that "man was born free, and everywhere he is in chains" (Du Contrat Social, 1762) appeared to be the value-laden assumption underpinning the writings of some adult educators, (e.g. Freire, 1972, 1985, Rogers, 1969, 1980, Brookfield, 1987), with the emphasis being placed firmly on the value of adult education as a means to secure freedom from some form of oppression towards greater cultural 'enlightenment', community participation and self-determination. Education as liberation from the supposed penury of ignorance is a common underlying theme. Hyland has traced the origins of this ignorance/ enlightenment view (and its legacy in the current academic/vocational educational divide) to the nineteenth century gentleman's [sic] ideal version of education, based on the supposed virtues of a classical education over the distaste for and evasion of the realities of manufacturing and commerce. He suggests that this may be rooted in Platonic ideas about the nature of knowledge and the true purpose of education (Hyland, 1994: 117).

Hughes et al (1995), however, point to the early works of August Comte in emphasising the emancipation of social thought from theological and metaphysical speculation. The need to identify and harness principles of social order and control over populations which had once been held in thrall by their perceptions of powerful monarchies and an all-knowing deity, gave rise to speculation over whether there were certain natural laws governing human behaviour. For Comte, the answer was to be found in Enlightenment 'scientific principles'. For others, the answer was a good deal more complex. Durkheim, for example, is said to have pioneered the use of quantitative analysis, using statistical methods in the study of society, while Weber "expressed doubts about the validity of viewing societies as structures, as wholes which had properties independent of the elements which composed them" (Hughes et al, 1995: 3).

Instead (according to Hughes et al), Weber advocated 'interpretative' methods which took human beings and their ideas and actions as the starting point for sociological analysis. Marx, however, apparently looked forward to a time when the natural and social sciences would come together to reveal the laws of social development, and to the improvement of society as a consequence of our acquired knowledge about society (ibid:15). Writing on emancipatory education, Fagerlind and Saha maintain that such 'liberation' schools of thought are:

"built upon the conviction that nothing good or profitable can be secured for the poor members of an underdeveloped society without a drastic and radical change in the structure of that society, as well as a broader radical change in the current socio-economic, political and cultural world order. The liberation theorists basically take a humanistic approach to questions of development. The underlying assumption is that members of the underdeveloped societies are oppressed by the powerholders of their own societies who control the relevant economic resources, such as land, industry and wealth. Some liberation theorists argue that the main remedy for overcoming this oppression lies in the education of the oppressed to be aware of their condition".

(Fagerlind & Saha, 1989:26)

They cite the "creative praxis of new society" advocated by the Brazilian educator Paulo Freire as a classic example of the perceived role of education in the liberation of people through the development process (see Freire, 1972:158). Although it is Habermas who has been credited with the concept of 'emancipatory learning' (Habermas, 1979), it would seem that this 'worldview' is just as prevalent today (e.g. Pollock, 1996). From this standpoint, then, the ideas which inform present-day adult education appear to echo some of the sentiments of early sociologists, even though their ideas seem to have been exchanged (especially regarding ownership and methods of analysis) between those thinkers who conceive of themselves as belonging to 'schools' of critical social theory, and those in the neighbouring discipline of psychology.

From the researcher's perspective, ideas relating to the grand science of social reconstruction envisaged by the so-called modernist thinkers of the 19th and early 20th century were an important consideration when attempting to assess the purpose and subjective value of an action research study which could be construed as being based on the premiss of social emancipation from perceived hierarchical constraints on the workforce. Any investigation of learning processes within the workplace therefore required an urgent consideration of the philosophical assumptions and (individual as well as collective) values underpinning the study. Reason, for example, has postulated that more modern definitions of action research represent a form of 'new paradigm' collaborative research which views research not as a neutral, value-free process but as a supporting and questioning initiative (Reason 1988 cited in Meyer, 1993:1067).

Did this therefore mean that *all* action research initiatives are based on the premiss that participants are in some way oppressed, and/or that the collaborative research process offers them the potential for reducing this burden of oppression? The notion of researcher as 'freedom-fighter', whilst an engaging and challenging prospect for some, left the present researcher feeling rather concerned and apprehensive, largely because of the volatile nature of the proposed research setting. Aware of being appraised by some employees as a 'manager', and by others as a 'go-between' oscillating between the perceived mutually exclusive territories of educational policy development and day-to-day practice, the researcher was deeply wary of appearing to assume any moral high ground as to the purposes and value of the action research process.

As Macintyre has observed, simply because managers see themselves as advocates of 'managerial' and 'organisational effectiveness' this does not give them the right to "conceive of themselves as morally neutral characters whose skills enable them to devise the most efficient means of achieving whatever end is proposed" (Macintyre, 1985: 74). He argues convincingly that 'effectiveness' cannot be regarded as a morally neutral value. But, neither then, come to that, are aspirations to social democracy, or attempts at social 'improvement'. It was clear, therefore, that while caution should be exercised by the researcher in making any unwarranted promises to those involved in the research as to outcomes, or proposed changes in policy and practice; the process itself could not be undertaken without recognising the personal and collective motivations and value-stances of the researchers involved. Any pretence at objectivity concerning the overall study would soon be rendered valueless in the face of the researcher's implicit need to gain access to participants and the research environment. It had already been made clear that access was possible only in exchange for some general contribution to nursing activity and welfare.

The possible generation of new knowledge in itself would not be considered sufficient justification to warrant the investment of time and emotional energy on the part of large numbers of participants. A careful line therefore had to be drawn: no promises would be made as to outcome, nor any claims made as to the moral virtue of the researcher. The ethos of the study would instead be subject to the consensus of participants, with the researchers acting interpretively through their status as 'equal partners'. Already the researcher was aware of submitting to and being submerged in the language of democratic participation (and without even trying!), even though the very idea of 'consensus' in itself seemed at that time to be potentially ambitious and uncertain.

From a 'liberation' perspective it was clear that the language of oppression and struggle already permeated the nursing discourse, (e.g. Mackay, 1989, Mason et al, 1991, Gibson, 1991, Hokansen Hawks, 1992, Witz, 1992) even though it sometimes professed an altruistic motive:

"There is little need for nursing to become a pillar of the establishment, there are more than enough of these. Rather, nursing must advocate a new form of professionalism in the acquisition of knowledge and skill, expertise or influence - some of the components of power - nurses can use these qualities not for their own self-aggrandisement or to control others, but to empower others to take control of their destinies for themselves" (Wright, 1986:2)

Wright declares that the "call to nurses to take on the mantle of change agency is also a call to take both political and personal action" (ibid:2). Therefore, by virtue of formal recognition of *being a nurse*, i.e. formal statutory registration, the researcher was already part of the maelstrom of political action for change whether she wished to acknowledge this or not.

Spaemann has argued that there are two ways in which our sense of values can become obscured - the first is "dullness of spirit", the second the "blindness of passion". "Right living" he believes, "means dealing fairly with reality" (Spaemann, translated by Armstrong, 1989:34). In so much as any researcher can claim to deal fairly with reality, therefore, it seemed both appropriate and fair that the collaborative action research process (in this case), should be carried out on the mutual assumption between researchers that a) individuals would contribute where possible to the collective appraisal of learning support processes in a manner to be agreed *prior* to the study's commencement; and b) that in the interests of the welfare of individual participants, absolute confidentiality of sources would prevail.

This mutual assumption would inform the research proposal on gaining access to the research environment, and anyone who felt unable to abide by its terms would be required to withdraw from the study, but not from the research environment, a subtle but important distinction which the researcher fortunately did not overlook! Whilst it could be argued that this in itself could be construed as a restrictive practice, in that participant confidentiality could be abused by the researcher undertaking the study, or used perjoratively by participants to conceal matters which otherwise should be revealed to those with a stake in the situation, (such as patients, relatives or colleagues within the workplace); the need for confidentiality was part of a larger issue concerning ethical research practice (see Dane, 1990). This amounts to "the protection of participants in a study such that their individual identities will not be linked to the information they provide[d] and will never be publicly divulged" (Polit & Hungler, 1993:433).

Thus the broader theoretical links regarding emancipatory learning were brought pragmatically to rest with day to day concerns. The language of "liberation" adopted by both adult education and nursing (e.g. Ford and Walsh's "liberation nursing", 1994:84), was to recur as a theme throughout the study. With the benefit of hindsight, it is interesting to see that the practical insights pertaining to research design allowed the researcher to link theory with practice from the outset - that is, despite early misgivings that to engage in *any* discourse of emancipation was to court disaster in relation to the positivistic ideal perceived of 'real' scientists. The acknowledgement of one's contextual position was not *ipso facto* an admission of researcher partiality or bias, after all, but rather the realistic and unalterable admission of one's perceived place in the world.

Given that the guiding aim of the proposed study was to closely examine the cultural values which predominated within the research environment, it was perhaps wise to recognise and acknowledge from the outset that one was already a 'native' in the ethnographic sense of the word! Or, as Hammersley and Atkinson have pointed out, it is important to be aware that abandoning analysis in favour of the "joys of participation" is a risk open to any participant researcher (Hammersley and Atkinson, 1995: 110).

Investigation into learning processes: the challenges ahead

Hyland states that "contemporary philosophers of education have been particularly concerned with the exploration and characterization of knowledge as a preliminary to making recommendations for educational practice", and stresses the need to distinguish "between knowledge as a body of ideas, facts or data (forms of knowledge, subjects or disciplines) and the 'conditions of knowledge', the criteria which have to be satisfied before any claim to knowledge can be confirmed or deemed justified" (Hyland, 1994: 64).

The educationalist Kolb has posited that if we are to understand learning "we must understand the nature and forms of human knowledge, and the processes whereby this knowledge is created" (Kolb, 1993: 153):

"Knowledge is the transaction between social knowledge and personal knowledge. The former, as Dewey noted, is the civilised objective accumulation of previous human cultural experience, whereas the latter is the accumulation of the individual person's subjective life experiences. Knowledge results from the transaction between these objective and subjective experiences in a process called learning. Hence, to understand knowledge, we must understand the psychology of the learning process, and to understand learning, we must understand epistemology - the origins, nature, methods, and limits of knowledge". (ibid: 154)

Kolb is critical of researchers whom he feels have failed to recognise the "intimate relationship between learning and knowledge", saying that common problems of barriers to communication and problem-solving occur where there are conflicting assumptions about the nature of knowledge and truth. This is reflected in a contemporary study conducted by Weil regarding adult learner's expectations of learning, particularly in relation to opportunities for learning within formal learning contexts (Weil, 1993).

Problems of 'disjunction' and 'integration'

Weil summarized the key issues emerging from the study around the conceptual formulation of 'disjunction and integration'. Her focus on adults' experiences in relation to these concepts highlighted the need for adult educators to recognise the possibility of alienating learners by virtue of leaving them with a "sense of fragmentation", involving issues of both personal and social identity. '*Disjunction*' seemed to occur when learners felt excluded from the learning experience for some reason, or in some way lessened or damaged by it. Although it was possible that disjunction could be used constructively to alter the learner's perceptions or world view of the situation, by implication it seemed to be possible to undermine the learning process by neglecting the learner's feelings with regard to learning, and the quality of support available for dealing with the learner's personal experience. In particular, feelings of disjunction were associated with perceived differences in the expectations of the learner, and in the assumptions and approaches operating with regard to teaching and learning.

The ways in which social differences and power relations were managed was considered to be important, as was the extent to which individuals felt 'threatened' or at risk within the learning environment. Other relevant issues concerned the management of conflicting roles, particularly for women in the study; and the impact of contradictions between tutors' private and public stances. Of special relevance to the proposed study of nurses' beginning practice were:

- * "the kinds of knowledge that were allowed or disallowed as a focus for critical reflection and analysis"

- * "the ways in which it was expected that knowledge and learning could legitimately be explored in that learning situation (such as through logical argument, supported by evidence, or through building and creating knowledge, drawing on sources including learners' experience);

- *the nature of the dialogue, relationships and learning processes experienced in the formal learning context;

- *the ways in which personal development and change were occurring: in spite of or because of what was occurring in a particular learning situation"

(Weil, 1993:162)

What is startlingly evident from Weil's findings (or at least the causal attributions presumed by Weil in her assessment and analysis of the findings), is the extent to which adults do indeed see themselves as having to fit into some coherent 'whole' within their everyday environment. The very concepts of 'disjunction' and 'integration' presume that there is something to integrate *with*, whether this is perceived empirically as the immediate learning context (i.e the lecture room, learning group and so on); or in relation to a wider concept of community, nationhood, or the individual's conception of 'society'.

It could be argued that the paradox of adult education - and attempts to define itself as a legitimate academic discipline and/or field of practice - lies in the very language it uses to define its problems; of which Weil's study is a good example.

Concepts related to disjunction and integration, such as 'access' to educational opportunity, liberally pepper the adult education literature, (e.g. Fulton, 1989, Wright, 1989, Parry & Wake, 1990, Duke, 1992, Calder, 1993, McGivney, 1993) as if there were some concrete barrier to educational opportunity that had been constructed independently of adult educators for the benefit of their analysis. It will be argued later in this thesis that adult educators have successfully moulded a Weberian "iron cage" of rationality from their attempts to derive a body of knowledge called 'adult education', by virtue of accruing and subsuming theories which (like those of early critical social theory) become *established* barriers to social emancipation, because of the uncritical consumption of value stances which are then integrated in to the knowledge base. This is not to deny the existence of problems affecting adult education practitioners and their 'learners', but rather to illustrate the potency and impact of language on our perceptions and practice, and therefore on our subsequent analysis of problems: a point which is central to this thesis, and which will be discussed in detail in chapters to follow. While it is enlightening, therefore, to take account of Weil's findings, it is also crucial for the researcher to take Mezirow's stance of educator as "cultural demolition expert" in order to reveal the various layers of assumptions which lie beneath the surface of opinion and assertions on the subject (Mezirow, 1985).

Problems of 'postmodernity'

Before going on to examine the problems of nursing's belief and knowledge systems, it seemed that some consideration of 'emancipation' from the viewpoint of contemporary social theory was necessary at this point, in order to place the assumptions of adult educators within their broadest cultural context.

In a thought-provoking seminar on adult education research and 'postmodernity', the Australian theorist Richard Bagnall stimulated discussion on the possible forms adult education might take in response to espoused social theories about the existence of and our reflexivity to human conceptions of living within the era of 'postmodernism' (Bagnall, 1992). The concepts and ideas he put forward have since formed an extremely insightful and illuminating backdrop to attempts to rigorously contextualise and assess the validity of adult education constructs. In the researcher's experience, although texts on social theory often refer to the concept of 'postmodernity', few seem able to define it adequately. Giddens (1990) is more successful than most when he points out that early definitions centred around postmodernity as "the replacement of capitalism by socialism". He outlines his broader conception of the term:

"Apart from the general sense of living through a period of marked disparity from the past, the term usually means one or more of the following: that we have discovered that nothing can be known with any certainty, since all pre-existing "foundations" of epistemology have been shown to be unreliable; that "history" is devoid of teleology and consequently no version of "progress" can plausibly be defended; and that a new social and political agenda has come into being with the increasing prominence of the ecological concerns and perhaps of new social movements generally....."
(Giddens, 1990: 46)

He also highlights what he sees as a common error; that of perceiving 'postmodernity' as *superseding* 'modernity', which if it were true, would be to "invoke the very thing which is declared (now) to be impossible: giving some coherence to history and pinpointing our place in it" (ibid: 47).

The failure of the 'Enlightenment Project' of the 18th century and later social thinkers to deliver the promised land of enlightenment sensibility, the hoped for moral progress and justice of institutions and happiness of human beings, (see Habermas, 1983, cited in Harvey, 1989: 13) is thought to have preceded a much more sobering human experience, some of which is blamed for 'shattering the optimism' of social thinkers to place their confidence in the future. As Harvey graphically explains:

"The twentieth century-with its death camps and death squads, its militarism and two world wars, its threat of nuclear annihilation and its experience of Hiroshima and Nagasaki - has certainly shattered this optimism. Worse still, the suspicion lurks that the Enlightenment project was doomed to turn against itself and transform the quest for human emancipation into a system of universal oppression in the name of human liberation" (Harvey, 1989: 13)

In a similar vein, the historian Eric Hobsbawm describes the experience of the "crisis decades" of an "age of catastrophe" which he sees to be the epitaph of [t]his "short twentieth century":

"Paradoxically, an era whose only claim to have benefited humanity rested on the enormous triumphs of a material progress based on science and technology, ended in a rejection of these by substantial bodies of public opinion and people claiming to be thinkers in the West...the moral crisis was not only one of the assumptions of modern civilization, but also one of the historic structures of human relations which modern society inherited from a pre-industrial and pre-capitalist past, and which, as we now can see, had enabled it to function....." (Hobsbawm, 1994: 11)

From this perspective Hobsbawm views the post-modern plight of disorientation not as a crisis of *one* form of organizing societies [researcher's italics], but of all forms. He describes our "strange calls for an otherwise unidentified 'civil society' and 'community' as "the voice of lost and drifting generations", in need of "traditional meanings" to define our life experiences, and presumably restore some sense of order and purpose to our world.

Different approaches to what Toffler foretold as our 'mass disorientation' therefore come into view (Toffler,1970). The sociologist Giddens could be interpreted as saying that our sense of history is false. If we have no past, therefore, can we hope for a *future*? The sixteenth century theologian Calvin, however, might have viewed the present human predicament somewhat differently, having a very pessimistic view of human nature; and seeing the 'Fall of Man' [sic] as a watershed in the history of human salvation, our present problems representing a fall from God's Divine Grace in no longer seeing the priority of God in the salvation of Humanity; the so-called 'doctrine of justification by faith' (see McGrath,1993:84-117).

Rather than perceiving us as lost generations, we would presumably be cast as "lost souls", as indeed we are by some religious fundamentalists in contemporary society. In relation to adult educational practice, then, we are open to multiple interpretations and attributions for today's human problems.

Bertrand Russell has written that when considering how to educate we must first be clear about the sort of result we wish to achieve. We must have some "concept of the kind of person we wish to produce, before we can have any definite opinion as to the education we consider best" he writes, in a somewhat bombastic and pontifical tone (Russell, 1926:33). R.S. Peters, in a similar treatise on the "aims of education" puts Russell's words into context when he writes that "in the old days, when the philosopher was thought of as 'the spectator of all time and existence', too much was claimed for the philosopher of education. It was thought that he [sic] could issue high-level directives for education, as well as pronounce on God, freedom, immorality and the meaning of life." He then adds the corollary, (somewhat wistfully in the researcher's view), that in more recent times there is a danger of too little being claimed (Peters, 1973:26).

Bagnall's conceptualisation of 'postmodernity' (Bagnall, 1994) and his assessment of its implications for research and adult educational practice are shrouded somewhat in jargon; but nevertheless have much to say to the contemporary adult educator. In examining what he calls the "dominant structural and curricular tendencies in post-modern adult education" he argues that adult education is *situational*, and represents a stance of indeterminacy, in so much as it rejects any hidden unity of underlying meaning to human action. It is *relativist*, in that no cultural traditions are regarded as being epistemologically or normatively privileged over others; it has *immediacy*, in that it exhibits what he calls "a contracted perspective of the future", and *retrospectivity*, in so far as "human action and action-events are viewed (deconstructively) from one's contemporaneous framework of meaning and identity".

Bagnall believes that there is a tendency for adult education to be 'commodified' or 'packaged' to suit the needs of the 'market', and so it is therefore valued on the basis of its *market value*, and measured subsequently on its sale and resale value in an open and competitive consumer market. He believes that it is also characterised and valued by its *instrumental value*, which he describes as being "directed to addressing ends, i.e for purposes beyond those of learning itself." It may also be *customised*, in that it is differentiated and tailored into pre-defined modules, and may be *needs-based* i.e. "responsive to and based upon the interests, felt wants, preferences or imputed needs of those individuals or categories of individuals for whom it is drawn together". The latter, he suggests, may happen in a straightforwardly responsive manner, or be subject to the "seductive moulding and cultivation of interests, wants or desires" (Bagnall,1992, unpublished lecture notes).

In this context he believes that postmodernity is informed by a belief and a commitment to what he describes as "the interpretive nature of all perception, the contingency of all belief, and the ontological contingency of being." In short, all interpretations are open to contention, all belief is contingent on perception and context, and, finally (and critically with respect to the researcher's own study):

"individual identity is self-constructed from the multitude of competing cultural discourses and models... it is fragmented and shifting among those discourses: giving rise to ambivalence and a profound existential insecurity..." (Bagnall,1992 op.cit)

Although it took some three years in the school of "the more I study the less I know" mode for the present researcher to grasp the relevance of Bagnall's assertions, the light has begun to dawn as to why so many hours were spent reading and attempting to make some coherent whole from the many and varied theoretical and ontological (it is now realised!) perspectives on what is considered to *matter* in relation to one's studies. At best, all that can be achieved is for the researcher to uncover another layer, or perhaps even a new dimension to what is already written about a given subject. Even then, it is necessary to recognise and allow for the extremely provisional and contextual nature of any departure from previous theory or practice.

It is perhaps important to stress that this represented an important stage in the researcher's personal development through the research study, for although this was probably recognised superficially at the outset, the extent to which all knowledge is transitory wasn't. This new realisation therefore reduced the perceived pressure to be aware of as many theories as possible: i.e. it was better to understand some theories in depth, rather than many superficially....

Nursing and Research: a Problem of Epistemology?

Mulhall comfortably attributes the nurse researcher's need to draw on so many sources to the "eclectic nature of nursing", saying that this may condition researchers into believing that they too should become knowledgeable and credible in many diverse fields. She is critical of what she describes as the "often acrimonious and largely futile debate" over the relative merits of certain research approaches in nursing. It would seem that "lost within this discussion was the recognition that, whatever methodology is adopted, nursing research is not solely the consequence of scientific progress" (Mulhall, 1995:557)

She agrees with others that like any other activity nursing research "is socially constructed, and in this case specifically forms part of the political and cultural project to establish nursing as a profession" (Chambers & Coates, 1992 as cited in Mulhall, op.cit).

It has been claimed elsewhere that nursing education is a political process which reproduces traditional practices, taking place in the context of a wider society where official discourse has always favoured the ideology of dominant groups and increasingly, economic expediency (Clare, 1993: 1033). Clare poses that "resignation to what seems inevitable ('it's just the system') maintains and recreates for the next generation of nurses the structures and conditions which prevent the profession from realizing its ideals" (ibid: 1035). The difficulty for nurses, however, say McWilliams and Wellings, is that the extent to which research requires "a stance of open-mindedness and the willingness to question, is inimical to the professional culture."

Nursing is an *expressive* art, they say, with the nurse acting to comfort and therefore "integrate the system" [which is here assumed to mean 'holding it together']:

"In our view 'research-mindedness' entails such questioning, and a basic part of the process of the nurse becoming a researcher is the sloughing off of those parts of the professional culture which determine how the world will be viewed"
(McWilliams & Wellings, 1985: 145)

On the one hand, then, nurses are supposed to be using research to enhance their status and chances of acceptance as a 'profession'. Conversely, they will only be viewed (by the research community?) as legitimate researchers if they succeed in "sloughing off those parts of the culture which determine how the world will be viewed". McWilliams and Wellings see 'twin cultural forces' acting as constraints on the nurse researcher: i.e. membership of an established profession [sic], and the organisational context in which nursing work is performed.

This is a good example of the peculiar form of sexist patronage afforded to nurses sometimes exhibited within the adult education literature in the researcher's view, and may be partly historical in that any account of nursing is inevitably gendered towards nursing as caring, and therefore 'women's work'. Davies, for example, has described nursing as an activity which "enables medicine to present itself as masculine/rational and to gain the privilege of so doing". There is a sense in which "nursing is not a profession, but an adjunct to a gendered concept of profession" (Davies,1995:61)

Nurses may therefore claim to be professional, in so much as they represent a *vocationalised* form of professionalism, based on subservience to medical hegemony and even notions of honour, supplication to higher forms of knowledge (i.e biomedicine) self-sacrifice, and what Friedson has described as "the spirit of service" (Friedson, 1975, cited in McWilliams & Wellings,op.cit). Nursing is therefore subject to a double-bind: it cannot emerge as a unique discipline because it fails to pass muster within the positivist tradition of science, even though it can be argued that "attempts to bring scientific equations into human relationships inevitably and necessarily demean them such that, ultimately, they become meaningless" (Clarke,1995:584). It cannot aspire to professional status, however, because it has so far failed to generate a unique body of knowledge validated by research. The imperative of professionalisation and a proper conceptualisation or 'epistemology' of nursing is by this argument doomed to failure, given its new-found acquiescence to the hegemony of science. Fawcett's rallying cry that "Nursing must be viewed as a profession rather than occupation and practice must be based on knowledge validated by research" rings somewhat hollow in the light of this 'double-bind' (Fawcett as cited in Bircumshaw,1990:1273). All of which brings us to the critical problem of 'epistemology' in nursing.

Playle blames medical hegemony and the "gatekeeping function of doctors" for exerting too controlling an influence on nurses and nursing research. The attempt to heighten the 'scientific status' of nursing and gain the regard which seems to be the corollary of this has led nursing "to adopt a predefined set of rules of the game" for the development of research teaching and practice. In his view nursing's inheritance of the "legacy of positivism" clearly establishes a positivistic bias and a 'natural science model' of research which is directly at odds with nursing's otherwise humanistic ethos. Playle believes that as a consequence of this contradiction fundamental philosophical aspects related to ontological and epistemological matters are rarely addressed, even though there have been "assaults" on this legacy from researchers within nursing:

"This legacy of positivism, in the attempt of nursing to establish a scientific knowledge base, has serious implications for the way nursing is to progress. If the teaching of research to nurses continues to be based on objectivity, empiricism and a natural science model, this will increasingly raise conflicts within the humanistic philosophy espoused for nursing practice....Nursing is at a point where it needs to acknowledge this contradiction in order to move forward"
(Playle,1995:982)

Playle argues that there needs to be a much closer analysis of questions of ontology and epistemology, and the social interests which have a tendency to influence what may be accepted as legitimate knowledge. The concept of hegemony must be taken into account. Nurses can make use of scientific knowledge and research but not by making themselves slaves to it: "the problems of decontextualisation, the search for universal truths and the assumptions of the value-free nature of such research must be made plain"
(Playle,1995:982). Nursing research must, in his view be "rehumanized" if it is to survive the conflict.

Elsewhere, the domination of the logical positivist philosophy has also been blamed for contributing to the dissonance felt between theory and practice, and for nurses failing to recognize and value the relationship between theory, research and practice (Wilson-Thomas, 1995:570).

'Epistemology' has been defined as "the theory or science of the method or grounds of knowledge" (Shorter Oxford English Dictionary (SOED):671). An immediate problem which had to be faced was that of the knowledge base acquired within the discipline of 'nursing' itself, for if no credible account could be made of what was *understood to constitute* 'nursing knowledge', then any inquiry into how nurses learn would be placed in jeopardy. Several writers have attempted to describe what is unique about nursing knowledge, and more pragmatically what constitutes 'good' nursing care (e.g. Carper, 1978, Fawcett, 1985, Ingram, 1991, Robinson & Vaughan et al, 1992, Farrington, 1993, Kitson, 1993, Robinson, 1993, Chinn & Kramer, 1995, Hogston, 1995, Bjork, 1995).

As Mulhall has astutely observed health care practitioners tend to need pragmatic answers to research questions, while the academic researcher may enjoy the "luxury of posing research questions, without ever facing the necessity of answering them!" (Mulhall, 1995:583).

Even Benner's oft quoted and much celebrated study of knowledge development in clinical practice (i.e from 'novice to expert', Benner, 1984) which was critiqued by the researcher in a previous dissertation, has been criticised for not giving in-depth consideration to the development of practical aspects of nursing care (Bjork: 1995).

As Bjork says, it is important not to forget the centrality of 'practical' knowledge to nursing, a reduced emphasis on which he believes is due to the natural effect of discarding the apprenticeship model of nursing education, and a reductionist approach which now relegates practical knowledge to the "isolated" behaviourist realms of 'psychomotor skills'.

Nursing, like adult education may therefore hold a greater claim to being a field of practice rather than a distinct discipline. As Bjork observes:

"the global and abstract character of the first nursing theories created a gap between the ideal 'ought to be' aims of nursing practice, and the actual tasks of nursing practice" (Bjork, 1995:10)

Interestingly, where an attempt has been made to develop insights into nursing practice and concepts central to 'therapeutic care', the involvement of practitioners in validating the evidence has been seen as crucial, and would support the view that more research studies should include practitioners in ways which might "empower and transform" them (e.g. Waterworth, 1995:13). The move towards 'problem-solving' approaches in nursing (typified perhaps by the patient-oriented individualised 'nursing process' approach of the late 1970s and early 1980s, see, for example, Roper, Logan & Tierney, 1980, McFarlane & Castledine, 1982); while ostensibly helpful to nurses for building their activities around 'realworld' encounters with clients and patients, is likely to experience difficulties under the more theory-specific approaches of preparation envisaged and now taking place within higher education (e.g. see Noyes, 1995, Macdonald-Scott, 1995). It is also important to recognise the cultural differences apparent within the nursing literature, in that the language used in the North American literature exhibits a more open and effusive sentimentality than is perhaps characteristic of Northern Europe.

Reed and Procter have argued that it is the complexity of humanistic nursing which presents problems to those wishing to define the knowledge base of the discipline.

They describe what they see as three separate movements or 'camps' in the current debate:

"there is the 'Academic Science' traditional scientific research approach, the 'Practice Knowledge' camp, which maintains that nursing is a practical occupation and as such should be learned through practice,...and the 'Radical Academia' camp [which is] in some ways a blend of the others in that it does use research, but is radical in that it seeks to uncover practice knowledge rather than develop abstract theory"
(Reed & Procter,1993:20)

However, Makin, (1995) has urged 'researchers' to beware of what he calls the syndrome of 'academic jealousy'; the diagnostic features of which include the "use of complex terminology, development of a specialist body of knowledge and an intolerance of the efforts of those who are 'playing at it'". He warns that exhibiting such tendencies can carry a "very real danger of pomposity" which can then potentially undermine the enthusiasm required for a healthy research culture, keeping the subject out of others' reach (Makin,1995:39).

Robinson takes a different stance, declaring that nurses sometimes show an unfortunate tendency to seize on certain analyses as though they were written in stone, not seeing that subsequent challenge and reconceptualization is an essential part of knowledge generation (Robinson,1993:81). There is some comfort to be drawn here then, in that nursing's aspirations to a more concrete nursing epistemology may yet continue, even if it is not yet clear in which direction this lies.

Social Constructionism and Nursing

It has been said that new policies and practices are products of their history (Carr & Kemmis, 1986:195). Social constructionists reject both the sociologist's point of view that it is social structures which lead to the social phenomena we see, and the traditional psychologist's explanation, which is that all phenomena can be found 'inside' the person, so that presumed entities such as attitudes, motivation and cognitions are responsible for what individuals do and say. Instead, constructionists regard the proper focus of enquiry as the *social practices* and *interactions* engaged in by people. Language is thus more than a form of expression: it enjoys an active and performative role i.e. "[W]hen people talk to each other, the world gets constructed" (Burr, 1995:7).

Processes are seen to be favoured over such "constructions" as personality traits or economic structures, so that "[K]nowledge is therefore not seen as something a person does or does not have, but as something people do together" (ibid:8).

From this perspective it is possible to view research itself as a discursive practice. By engaging nurses and their colleagues in reflective discussion, and by collectively documenting and analysing the debates and social outcomes which follow, it is therefore possible to develop theory from discourse. Such theory would have to be recognised as discursive of course, as constructionism rejects absolutely the existence of any objective 'fact'. Numerous social constructions of nursing and nurses can be found in the literature, most emphatically in the early debates concerning vocationalism, the struggles for formal national registration and governmental recognition of the nurses' contribution to health care.

The sociologist Abigail Perry provides a splendid example of how certain values can emanate from a piece of writing. In a discussion on what she calls "the handmaiden's theory" she provides a fairly caustic account of what ails nurses as a group of workers:

"Doctors need clever pairs of hands to assist them in their technical tasks. Hospital administrators need well-regimented pairs of feet which respond in uniform ways to different marching orders and constant changes in the battle plans. Patients need human compassion, carers who respect them as persons and not merely as bodies. All these groups want what money in a money economy does not necessarily buy. They want the *love* of worker bees, with their dedication of purpose, superb instincts and organisational skills. Who tries to live up to these almost impossibly high and unstated expectations in human caring and who therefore suffers the personal consequences of failing to meet all these needs? Usually nurses in health and usually women in the family and society generally" (Perry, 1993:62)

In Perry's view then nurses could not be expected to develop a distinctive knowledge base in a cultural milieu which has inherent structural biases and problems.

Constructionists might argue, however, that this is only one way of looking at the power relations experienced: that this is only one discourse, and a very disabling one for nurses in that it encourages them to 'frame' their view of themselves in negative and perhaps even defeatist language. The possibility for examining alternative worldviews through discourse arising from the introduction of formal learning support, in this case preceptorship, and reflective, dialectical discussions on what values nurses wish to promote and pass on to future generations of nurses therefore counters some of the philosophical problems already discussed in this chapter. The first is that of empowerment. Is it possible to help nurses 'reframe' their positions as powerful as opposed to powerless?

And second, can providing opportunities to staff to see how social discourses can transform themselves into social actions through negotiated understandings help them to articulate what constitutes distinctive *nursing* knowledge? Ambitious though it may seem, the primary researcher hoped to help nurses in the workplace to negotiate a better understanding of the ways in which learning could take place through the constructive and critical examination of taken-for-granted practices in their world. The next chapter attempts to describe and explain the mechanisms used to bring this about.

Study Design and Process Management

Exploratory designs in nursing research

Exploratory designs have only recently taken their place alongside descriptive and experimental designs as valid means for gaining knowledge and building theory in nursing (Brink, 1989). Qualitative researchers understand that they are actors in the research process, rather than impartial observers of the process itself (Maykut & Morehouse, 1994). Brink summarises the application and utility of exploratory designs describing them as those which:

" use qualitative data collection methods based upon unstructured interviewing techniques, unstructured observations, unstructured available data, small samples, and a variety of forms of content analysis. They are purposefully flexible, allowing researchers to discover new phenomena or to gain new insights into known phenomena. They are also insightful, allowing for the development of new ideas, theory, and concepts. These designs enable the researcher to intuitively rearrange and make sense of the known universe, opening up an entirely new field of research in the process."
(Brink, 1989: 142.)

She claims that to be effective such research should involve "minimal investigator control over data" but rather that the data should control the investigator, thus giving the researcher sufficient flexibility to "challenge accepted reality and explore it for its own reality, to accept other people's rules and judgements as basic premises, to set aside prejudices and prejudgments as far as possible, and to record phenomenon as they are, rather than as the researcher would like them to be" (ibid: 145).

Other qualitative researchers are more structured in their approach, recognising that while data collection may be relatively unstructured, an overall framework for collecting data should be included, for example in preparing an *interview guide* which highlights topics drawn from the researcher's own personal knowledge and experience of the area, and preliminary work such as informal discussions with informants or perceived experts in that area (King, 1994:19). As Sapsford and Abbott have observed, "[A] great deal of social science research is concerned with the asking of questions, and a substantial technology, folklore and body of expertise has grown up around the art and science of asking them" (Sapsford & Abbott, 1992:9).

Nursing's 'research dichotomy'

Hardey has described two models of research in nursing, the '*generalist*' and the '*minority*' models. Arguing that research will be of little use to nursing and health care unless it is properly disseminated and used to improve practice, he goes on to describe the generalist model as that which is informed by nursing knowledge and supported by the continuous research activity of qualified nurses: "Research in this '*generalist*' model is thus an integral part of professional nursing and is egalitarian, in that all participate in it" (Hardey, 1994:163). The '*minority*' model accepts the separatist approach in that nurse researchers conduct research, while nurse practitioners (i.e. practising nurses) don't, relegating nurse researchers to a perceived ivory tower concerned with the advancement of knowledge "not necessarily related to any specific problems identified through a practice-based profession" (ibid:164). Buckeldee and McMahon blame the way in which research is taught to nurses for some of the problems experienced, confirming the view that nursing research is seen as elitist as far as some practitioners are concerned.

They cite Reed and Robbins, who feel that the use of complicated terminology and jargon has alienated and confused the uninitiated among nurses (Reed & Robbins, 1991, cited in Buckeldee & McMahon, 1994:3).

Orthodox scientific inquiry is based on the dogma that the researcher is in some way a different animal from the subjects [sic] being studied (Reason, 1994: 11). Adherence to this world-view in the past, so that nurses were seen as the subjects, while researchers viewed themselves as objective observers, may therefore explain nurses' relative passivity and perceived low status in comparison with other health care workers. This is certainly the case in the researcher's experience of nursing work.

It is thought that one result of this may be that there is a loss of what was previously perceived as 'concrete' knowledge, because the Western emphasis on intellect as the primary means of knowing and the power of conceptual language has traditionally been maintained:

"This results in the separation of intellect from experience, so that knowledge that comes in propositional form is valued more highly than intuitive, practical, affective, analogical or spiritual knowledge This reinforces the tendency to think in terms of parts rather than wholes, things rather than processes: naming the parts of the world creates an illusion of real separate objects; concepts drive a wedge, as it were, between experience and understanding".

(Reason, 1994: 12)

Reason reminds us of his earlier conclusion that "in grasping for control and knowledge we have lost a sense of what is whole and holy" (Reason, 1993 in Reason, 1994: 13). In seeking to do justice to nursing research, therefore, it is plausible to consider methodologies which 'speak to' those involved in nursing practice, and which involve them in a process of participation through collaboration.

Research utilization in clinical practice can become a reality when nursing education and nursing service collaborate (Sneed & Strong, 1993: 42) However, it is easy to subscribe to the notion of participation. Reason has warned that while the notion of participation carries strong positive connotations for many people, it is "very easy to espouse participation and yet at times incredibly difficult to practice genuinely" (Reason, 1994: 3). Research which is designed for the stated purpose of improving practice could in itself carry all manner of open and hidden agendas, and therefore could arguably be conceived of as a political exercise. Any choice of process or method is subject to competing pressures and influences, not all of which may be benign to those involved in the research. It is important to acknowledge that differing worldviews also affect the way research is evaluated and interpreted, either by researchers or, ultimately, by its consumers (Dane, 1990). Adult education research is therefore capable of challenging established worldviews and conceptions on adult learning and development, although its effectiveness to date has been called into serious question (see Hart, 1992: 199).

Calling adult educators to account

Mechthild Hart has scathingly criticised adult education responses to what she calls the "current turbulence in the world of work", arguing that adult educators have misguidedly subscribed to assumptions made by a prevailing industrial-patriarchal concept of work. She argues that a strong economic interpretation of work and work related knowledge and competences "all of which are tethered to the unquestioned ideology of continuous and unlimited economic growth", is responsible for incurring tremendous social and environmental costs and profound social and economic injustices which "fixate" the learners to choices which do not provide real alternatives, either individually or socially.

Hart believes that adult education needs to be:

"called to account for its inability or unwillingness to provide more critical and creative responses to current crisis surrounding the issues of work and employment. However, it must first of all let go of its fixation on merely 'building a quality workforce' which will contribute to effectiveness. Adult education would have to see the current troubled experiences of work, accompanied by doubts, problems, dissatisfactions and sufferings as an opportunity for asking critical questions, and for opening up at least the conception of new possibilities for living and working. To feel the pulse of these kinds of changes, to be a midwife to these unborn ideas, to articulate them and give them means of social expression which would make them conscious and actionable - this should be an educational task of primary importance" (Hart, 1992: 200).

Hart is particularly concerned that adult educators help to "systematically unveil the real lines of dependency" affecting human beings, acknowledging first of all that humans are dependent on nature for their survival. Adults need to know and understand the ecological consequences of their ways of working, and to recognise ecological principles which can help to raise their awareness of the human misery and destruction created by working for short-term gain.

Importantly for the researcher's present study, she also urges adult educators to forego "the current Greek chorus on looming crises and disasters" which seeks to disable people by focusing on so-called deficiencies in narrowly defined skills, thus making adults timid and fearful of opportunities, anticipating failure.

She stresses the need to build "relations of support" :

"[C]urrent and developing forms of workplace organisation in many instances destroy the last vestiges of a work-related social culture. Despite the emphasis on teams and other forms of collaborative work, these new forms are instituted from above, as well as highly regulated and controlled.....Adult educators can explore together with their students ways of creating a work environment where individual workers can rely on mutual support and encouragement, thereby strengthening the attempts to shape this environment in accordance with worker-defined needs and interests"

(Hart, 1992: 206)

The concept of *critical thinking* is central to the aim of increasing worker democracy and relations of support in work organisations, as Brookfield has outlined. Critical thinking is evident whenever employees question the appropriateness of a certain practices, modes of production, or organizational forms:

"Managers who are ready to jettison outmoded organizational norms or unwieldy organizational hierarchies, and who are prepared to open up organizational lines of communication in order to democratize the workplace and introduce participatory forms of management, are critical thinkers....Critical thinkers see the future as open and malleable, not as closed and fixed. They are self-confident about their potential for changing aspects of their worlds, both as individuals and through collective action." (Brookfield, 1987: 4-5).

The risk of 'educating to oppress'

The Brazilian educator Paulo Freire's social pedagogy defines education as a place where the individual and society are constructed, and as a social action which can help to empower or domesticate students: "This pedagogy challenges teachers and students to empower themselves for social change, to advance democracy and equality as they advance their literacy and knowledge" (Shor, 1993: 25).

Lankshear has, however, challenged the commonly held 'functional' view of literacy as a narrow conception of Freire's call to promote human rights by enabling adults to recognise the forms of oppression which reduce them to cogs in a machine. Human beings are capable of much more than being taught to read and write. He cites Kozol's outright rejection of all forms of adult literacy programs as an "unworthy goal to be pursued" (Lankshear, 1993: 91), recognising the paradox inherent in the use of functional literacy which "aims to equip illiterate adults with just those skills and knowledge - no more - which ensure 'competence to function at the lowest levels of mechanical performance', as workers and citizens in a print-dominated society" (ibid:91).

According to Lankshear, Kozol finds it "morally repugnant, if not dangerously insane, to adjust people (through making them literate) to daily routines which are integral to one nation's pursuit of global domination, when the price of that pursuit could well be global annihilation" (Lankshear, 1993: 92, Kozol, 1985). Freire himself has warned against the dangers of educators acting paternalistically, and in an 'anti-dialogical' (one-way) manner. As people strive to be more human, the elites are said to present a false picture of reality, through which education must be presented as something fixed and given, to which humans "as mere spectators, must adapt", and not as an ongoing challenge to be met in dialogue (Lankshear, 1993: 102).

Alternative methodologies considered

The paradigms for conducting social research seem to be shifting beneath our feet, with an increasing number of researchers now seeing the world with more pragmatic, ecumenical eyes (Miles & Huberman, 1994: 4).

Miles and Huberman believe that there is a need to share more about our 'craft', so that it is possible to develop practical standards which have the potential to work across different perspectives in judging the "goodness of conclusions." They conclude that "Even if we happen to be dubious about post-positivist canons, we are still accountable for the rationality and trustworthiness of our methods" (ibid: 5).

As a beginning research student the literature and ideologies concerning research are daunting, not because they demand rigour, but because they require the synthesis and understanding of many contradictory and diverse views on the 'right' ways in which to conduct research as regards the infinite variety of settings, participants, audiences, consumers and demands of different researcher communities. The temptation (personally) to focus on one perceived 'method' and cling to it resolutely- forsaking all others - from the beginning, was the first of many 'tests' to be overcome in this researcher's experience . An early review of introductory texts on research offered numerous conceptual pathways through the more detailed and complex literature.

Given the researcher's earlier aspiration to 'empirically test' a model of transitional learning support described as *preceptorship* and devised for use following a systematic review of the social support literature and subsequent contextual policy analysis, the first design considered was that of experimental, or quasi-experimental design.

Experimental or quasi-experimental design.

The attractions of experimental design are three-fold. Firstly, they can afford the researcher the luxury of feeling that the research is traditional in design and conforms to the requirements of positivist science i.e. the 'view from above'. Experiments seek to explain the behaviour of people or things in relation to certain laws (Robinson, 1993:50). Such an approach has dominated medical science - and therefore health care- for several centuries (Weatherall:1995). Science is seen above all as experimental (Preece,1994). According to Robinson, experiments involve the researcher taking a view on what they think is likely to happen, and then producing the research to support or contradict this view. This view, or *hypothesis*, she describes as "a sort of hunch about the phenomenon being studied. The research process involves formulating a hypothesis, carrying out the research to obtain data relating to that hypothesis, and then analysing the data to determine whether the data [sic] was 'right'" (Robinson, 1993:50). In the scientific approach, writing an hypothesis comes *after* identifying the research problem and a review of the literature, and as such "offers a possible explanation for a research problem" (Couchman & Dawson, 1990:58). An experiment has been defined as "a study undertaken to test one or more hypotheses and in which the relevant variables are controlled and manipulated by the experimenter, rather than simply involved in the natural setting" (Miller & Wilson, 1983, quoted in Couchman & Dawson, 1990:59).

Secondly, theory and previous research puts scientific researchers into a position of knowing what it is they are looking for, in that they have specific hypotheses to be tested (Robson, 1993:19). This is alluring to the neophyte researcher in that this seems a relatively straightforward matter.

However, scientific research is also about the identification and study of the effects of variables and ways in which they are inter-related, variables being described generically as "any quality of a person, group, or situation that varies or takes on different values" (Polit & Hungler, 1993:28). Research 'control' is central to experiments in that it is "concerned with holding constant possible influences on the dependent variable under investigation so that the true relationship between the independent and dependent variables can be understood" (Polit & Hungler, 1993: 34). There is also the challenging issue of external influences or factors, both in assessing the value or 'trustworthiness' of a given method and the extent to which the researcher has adequately and appropriately 'controlled for' these influences (ibid:36).

Thirdly, experiments seem to convey an ordered and logical approach to data collection, analysis and synthesis, in that there is less obvious concern with the muddy, messy issues of personal involvement in the research process. The researcher is ostensibly distanced from the process by virtue of measures aimed at obtaining the control of variables. On further investigation, however, the apparent chasm between positivist and non-positivist paradigms is more complex. Cohen & Manion describe two approaches to research, namely the *normative* (or positivist) paradigm as already described above, and the *interpretive* paradigm. The normative researcher "tries to devise general theories of human behaviour and to validate them through the use of increasingly complex research methodologies which, some believe, push him further and further from the experience and understanding of the everyday world and into a world of abstraction" (Cohen & Manion, 1980:39).

The interpretive researcher on the other hand begins with the individual's interpretations of the world: theory is therefore emergent "and must arise from particular situations; it should be 'grounded' on data generated by the research act" (ibid:39). They say it must also make sense to those to whom it applies, although this has been contested elsewhere. Dey, for example, has argued that while we can learn from the subjects [sic] of our research and modify our analysis accordingly, we cannot allow them to be its final arbiters:

"Even if our account makes no sense to the subjects of our research, even if they fail to recognize the relevance of our interpretations, even if they reject the value of our explanations, we are entitled to persevere with our analysis. The validity of our account does not depend on acceptance by those who are a subject of it. Indeed, a critical account which reinterprets social processes and events may be deliberately set against the current preconceptions of those who are subject to the research"
(Dey, 1994: 235).

Early plans to introduce the newly devised model of preceptorship to a representative population, and then to identify and monitor a control group which shared the same characteristics (i.e. dependent variables), but did *not* introduce the new model to their everyday practice, were fraught with difficulties for several reasons which will now be explained. Some of these were contextual, in that there were important practical reasons why this experiment could not be conducted; and others were ethical, in that they would fail to address some of the necessary prerequisites to ethical research practice. The adoption of an experiment could be seen as paternalistic/maternalistic in its approach to the prevailing problem of lack of social support.

Given the need to involve participants on an equal basis with the researcher, an experiment could be criticized for failing to adequately take account of the participants' perspectives. Theory would therefore be tested without having first of all having 'emerged' from the data being collected, so that assumptions made by the researcher might not be correct.

Similarly, such a process could be perceived as anti-democratic and autocratic, by neglecting the possibility of shared data collection and analysis, and therefore imposing the researcher's views and prejudices on a participant community which was already reeling from massive organisational restructuring and extensive 'innovation fatigue'. An experiment would also be non-collaborative, in that it sought to observe participants, rather than engaging them in any exploration of critical values and assumptions underpinning new role learning. This would then fall into the category of the 'minority' research model described by Hardey (1994). In Freire's terms it would also be 'anti-dialogical', in that it represented a 'one-way' analysis, without respecting the potential contribution of individuals to their conscious, collective actions.

The critical theorist Habermas has gone so far as to say that 'truth' may only be determined to the extent that it contributes to the goal of emancipation, the truth of a theory not being dependent on the application of certain methodological principles and rules, " but on its potential to orient the processes of praxis towards progressive emancipation and humanization" (Mies, 1983:124, in Hammersley,1990:66). As such, therefore, an experiment would also abjectly fail to help the population unveil the real lines of dependency affecting their lives, perhaps adding to rather than subtracting from the felt pressures within the work community, as envisaged by Hart and discussed earlier in this chapter .

Other reasons for rejecting the experimental method concerned contextual issues. The statutory bodies for nursing had already recommended the introduction of support roles to assist the newly qualified (even though they were vague as to the details), and had stipulated a starting date of April, 1993, following the publication of a formal letter of guidance to employers in January, 1993 (UKCC,1993).

Although this was not to be a statutory recommendation, the onus to provide such support was clearly on employers from that date onwards. The logistics and organisational costs and mechanisms for doing so were left to individual NHS and independent sector employers, supported by access to nurse advisers in Regional Health Authorities (RHA).

Because of an interest in this area the current researcher was approached and subsequently directly involved in the policy deliberations concerning this at a regional level, and was able to assist the process in providing the background theoretical material and working definitions required in a subsequent discussion paper, which was then disseminated across colleges and employing authorities for use across the region (Nursing Directorate, WMRHA, April, 1993a). A regional conference was also organised and led by the researcher, with a view to considering the possibilities for the immediate implementation of some elementary form of support role being introduced to the workplace on a region-wide basis. Delegates' discussions and contributions were used to inform the present study and its policy adjunct: the regionally funded parallel RHA supported project which assisted staff in introducing new learning support to their area of practice via open learning (Morton-Cooper, 1994).

The conference proceedings were published and disseminated regionally and to professional organisations and the relevant committees and officers of the UK statutory bodies (WMRHA, April, 1993b). Initiatives were therefore well publicised, with many staff expressing an interest in becoming involved in the implementation of preceptorship to their respective clinical areas.

It became clear therefore that any use of a control group which would not be able to *benefit* (as was the perception) from such involvement was therefore impractical - even unethical - in that to deny involvement was both in contravention of directives from the UKCC, and unfair on those who were to be denied access to support which was going to be made available to others. Although it could be argued that 'they would never miss what they had never had', the political and ethical implications of such a move would clearly be problematic. They were likely to lead to protracted negotiations for access within the field areas anticipated. The thorny problem of allocating newly qualified staff to areas and then asking supporters to purposely deny them support was also clearly unethical and unworkable. The viability of an experiment could therefore be seriously disputed, and so was abandoned in favour of a more democratic and collaborative approach.

Survey methods

As a possible alternative, the use of survey methods to clarify areas of central concern to the study was seriously considered in the beginning stages.

Survey techniques such as structured or semi-structured interviews and questionnaires were very familiar to the researcher, largely because they constituted a popular method in researching nursing activity, and had been used by colleagues investigating other subjects and issues within nursing and health care within the researcher's everyday work environment. The researcher was concerned, however, with the limitations of survey methods, recognising that any desire to uncover in-depth or deeply personal knowledge would be difficult given the impersonal nature of questionnaires, and as such would fail to extrapolate differences between cultural knowledge (i.e. knowledge belonging to the nursing culture) and that which had been arrived at independently, or in spite of, belonging to that culture. Such investigation required a more catholic interpretation of the research question which would be better served by focus groups and follow-up interviews conducted within the natural setting. The researcher was also aware that the clinical setting had also recently been the subject of extensive internal and external auditing procedures. This had demanded considerable attention and extra work from employees, leaving them with a sense of having been 'worked over'.

A further intrusion by postal or internally circulated questionnaires seemed both insensitive and impractical; particularly as it was likely that response rates would be poor, and any enthusiasm for the research itself lukewarm. They might also imply a 'top-down' approach to the research which would be misleading and could have a detrimental effect on those responses offered. The potential insights to be gained from interview data did not escape the researcher, however, and it was the extent to which this approach might succeed which constituted the main focus of the initial pilot study which is considered in more detail below.

Participant observation

The goal of qualitative research is to discover patterns which emerge after close observation, careful documentation and thoughtful analysis (Maykut & Morehouse, 1994: 21). Kleinmann & Kopp have observed that "in order to gain acceptance, fieldworkers may avoid areas that others consider unworthy or impure", finding that they begin to compare their own studies with others which have met required standards. Sometimes researchers are unaware of stigma attached to a study until they enter the field, and it is important to recognise that "the value others place on our project affects how we feel about it and ourselves as fieldworkers" (Kleinmann & Copp, 1993:7). Researchers who are positivistically inclined tend to "look to reliable and valid non-human instruments of data collection and statistical analysis, while the qualitative enquirer looks to in-dwelling as a posture and to the *human-as-instrument* for the collection and analysis of data" (Maykut & Morehouse, 1994:26).

These authors have argued that the human instrument is the only data collection instrument which is sufficiently responsive and complex to "capture the important elements of a human activity or enquiry" (ibid:27), although this would seem to be a rather partisan view which negates the important contribution to be made by the 'hard' methods to human knowledge and understanding. As Field and Morse have explained, it is up to the researcher to select appropriate methods according to the nature of the problem, what is known about the phenomenon being studied, and the maturity of the concepts being discussed. In this way it is possible to extract the best of both quantitative and qualitative paradigms, mixing them either sequentially or simultaneously (Field & Morse, 1985:15).

Participant observation can involve researchers at various participatory levels, e.g. participant as observer, observer as participant, complete observer (implying a passive role) and complete participant, where the "observer enters the setting as a member of the group and conceals the research role from the group" (ibid: 76). Archer and Whitaker have made the point that research partnerships work best when a spirit of collaboration exists, together with a prevailing sense of mutual respect between those participating in the project (Archer & Whitaker, 1994). Covert research is both difficult for the researcher and potentially fraught with ethical problems, not the least of which concerns the practice of deception and the possibility of causing psychological harm to participants, and the failure to secure their informed consent (see Dane, 1990).

In the present study, lack of informed consent would render the study invalid as participants could legitimately deny ownership of any feelings or opinions expressed, perhaps arguing that these were taken out of context by the researcher. It was also difficult to identify any possible gains from conducting research covertly in the present study, and so its use could not be justified.

Having rejected this option then, the remaining possibilities concern acting as 'participant observer', 'observer as participant' and 'complete observer'. The option of *complete observer* was immediately recognised as impractical and undesirable from the outset, first of all because the researcher was subject to the time constraints of a full-time career and family life and a part-time research degree. As Blaxter and Tight have concluded from their study on how adult students manage their time alongside other responsibilities and activities, older students are at times perceived as having no other major commitments, despite evidence to the contrary.

The researcher would agree with their assertion that the reality of students engaging in study to improve their life chances "is being achieved by placing a disproportionate element of the responsibility and burden upon the individual adults themselves" (Blaxter & Tight, 1994: 178). Any decision over appropriate data collection methods therefore had to be judged accordingly, with concerted attention being paid to the feasibility of the study with regard to time factors, the availability of subjects and the likely co-operation and support of others (Redfern, 1984). Again it was doubtful whether there was much to be gained from acting as a complete observer, when the study intended to assess the interpersonal aspects of adult role learning. To do so would exclude the researcher from any meaningful interaction with the research process.

In asking whether it is possible or necessary to devise a useful theory of workplace learning, Billett has expressed a need to "stand outside of the existing model of learning through formal settings" so that processes of 'enculturation' are properly addressed. The workplace is qualitatively different from conventional formal education settings in terms of 'key intent': "Consequently, any learning theory has to take account of settings, enculturation and the social contribution to the learning in addition to considerations of how knowledge and procedures are structured by settings" (Billett, 1992:152).

Observation from afar was therefore unlikely to provide the richness of data required for such an exploration, and would certainly lack the depth of analysis necessary to interpret evidence confidently and with sufficient credibility.

Field and Morse have described the role of '*participant -as-observer*' as one in which the participants in the setting are aware of the researcher's purpose and dual roles. However, they have also warned of the potential role conflict which can occur as a result of nursing work being interrupted by research activities. The researcher's first responsibility is to the patient, in their view, and as stated in research guidelines such as those suggested by the Royal College of Nursing here in the UK (Field & Morse, 1985).

An incident which occurred while the present researcher was visiting a neighbouring hospital (as a guest speaker) is a case in point. A patient collapsed unexpectedly, and as the staff and a relative rushed to his aid, the researcher was aware of the reactions of an inexperienced and shocked staff nurse standing close by: a situation which lay outside the reach of normal research practice, and fell instead into the category of one human being comforting another.

Later it was possible to reflect on the notion that such conflicts were indeed possible and perhaps even to be expected within a normal working day in a busy acute hospital setting. As far as this study was concerned, the researcher was (theoretically!) freed from this immediate source of conflict by virtue of her managerial role. It was nevertheless noted as a potential problem should any clinical involvement in care ever be considered in the future. This left the remaining option of '*observer as participant*', where the researcher is freed from the 'work role' shared by other participants.

The main disadvantage identified with this approach is that of the researcher being considered an 'outsider' by the staff and "not trusted or given access to the insider's perspective of the phenomena" (Field & Morse, 1985:77). To what extent did this matter, and who, if anybody, would be acting as 'gatekeepers'? Punch (1984) has studied and articulated those factors which can have a material impact on qualitative research accounts and which he believes "shape the politics of research". These include researcher personality, the geographic proximity of the researcher, the nature of the research object, the researcher's institutional background, status of field-workers, expectations in team research, the impact of publishing the findings, and the social and moral obligations generated by the fieldwork (Punch, 1984: 86-88). He is wary of the "determination of some watchdogs to protect their institutions [which] may ironically be almost inversely related to the willingness of members to accept the research" (ibid:86). In his view, gatekeepers take many different forms and can materialise from nowhere, so that "academic imperialism" and status may play its part.

The decision to undertake the role of '*observer as participant*' therefore required an analysis of possible gatekeepers and 'sentries', and a pragmatic consideration as to how the researcher might have to respond to any involvement or suggestions offered (or imposed) by gatekeepers with different motivations and priorities.

It was clearly the case that funding for the study had ultimately been received from the RHA because of the positive outcomes of related non-research led professional activities being conducted by the researcher, and the communication of these through the nursing networks and media.

The researcher could therefore be construed as the gatekeeper from the perspective of participants (as was sometimes the case), being perceived as 'a rising star' with a reputation to develop, and therefore sharing a research agenda with the sponsoring authority. This was a difficult issue for the researcher to address personally, as it was also important to address such matters as researcher independence and autonomy. For example, in producing open learning materials for the funding body, contractual arrangements had already been set up, recognising the researcher as 'author' of the work and therefore the legal copyright owner. Any perception that the researcher was likely to materially benefit from the research was an equally sensitive issue, particularly when participants were being asked to take time from a busy work schedule to take part in the study.

Having taken the advice of an experienced mentor who had many years of fieldwork to draw on, the researcher decided to make this part of the activities explicit to participants, and was in fact rewarded (and somewhat bemused) by the response of "well at least we know it won't be consigned to the bin of research history!" It was soon recognised that the researcher's position was in fact made more tenable by the likelihood of the findings being published, although this obviously made any pressures on the researcher to later withdraw from the project for family or other reasons potentially very awkward.

The need to enter into a research 'bargain' in order to gain access to the field soon became obvious, and it was the nature of this reciprocity that eventually determined the nature of the researcher's role. The feminist reciprocation of "providing support and a mouthpiece against injustices" (Skeggs, 1994: 81) was rejected by the researcher in principle, simply because she was cautious of imbuing everyday interactions with a strongly political overtone.

Whilst wishing to examine the gendered nature of responses acquired through the project, including her own, it was nevertheless problematic to assume an emancipatory role on behalf of a population which had not yet had the opportunity to express a wish (or even inclination) towards it. It also did not take account of the phenomenon peculiar to nursing work, which is that despite being a predominantly female occupation, it is men who lead nursing in terms of management ideology. Almost half of the UK workforce is female (45%), but within nursing this rises to 90%. Little data is published on the ethnic mix within nursing, and "studies have found that even in comparison with their full-time female colleagues, the number of men in the higher positions in nursing is disproportionately high" (see Robinson, K.1992: 26). It was important to document and account for what Glucksmann has described as inequality of knowledge in the research situation derived from "socially determined structural divisions in knowledge between people formed in society at large" (Glucksmann, 1994: 156).

This is said to include differences in life histories as regards formal educational experience, qualifications and skills possessed and type of professional or vocational training; or what has been described by Lillyman as 'credentialling' (Glucksmann, 1994, Lillyman, 1996). Given the realistic possibility of 'stereotypes' emerging in the study in relation to nursing work, it was also vital to consider developments in the study of social stereotyping, and the dynamic relationship which is said to exist between stereotyping and reality (Oakes et al, 1994). It was necessary to consider the implications of research bargains for research relationships and for their likely effects on the institutions and work environments of participants. Short-term gain would be unwise if in the long-term negative effects were likely to be felt.

It was therefore time to conduct a pilot study of 'stakeholders' in the field which would clarify and help to establish ethical boundaries and an appropriate conceptual framework for the proposed collaborative study.

Conduct & Outcomes of the Pilot Study

Contextual background

The discipline of nursing is said to be in a period of rapid transition from that of nursing as a vocation to that of profession (Van Maanen, 1990). Nursing educators are being challenged to integrate critical thinking and reflection into nursing curricula, even though present conditions in education and the nursing service are "often seen as destructive, both of individuals and the profession as a whole" (Spence, 1994: 187). The professional socialization of nurses has been roundly criticized for the apparent role conflict it produces in individuals (Shead, 1991), with the "reformist literature" being blamed for overlooking the outcome of inadequate socialisation processes, namely, that they "tended to lead to an apparent and relative desensitization of some student nurses to human need" (Greenwood, 1993: 1471).

It could be argued that the ritualized 'status passage into nursing' demonstrates nurses' collective inadequacies in coming to terms with the emotional components of their interpersonal roles (Bradby, 1990). The ability to care appropriately in line with professional and public conceptions and expectations of what 'caring' involves has continued to challenge the emotional reserves of nurses, perhaps because of an inadequate conceptual basis for the understanding of the concept of care (Scott, 1995a).

It has also been said that, historically, nursing has been deficient in providing adequate recognition for a job well done (Donovan, 1990). The extent to which nurses care for and about each other and their situations, and their relative status in health care generally, would seem to suggest that whilst they are publicly lauded for their contribution to care delivery, this appreciation is limited and does not necessarily lead to commensurate financial reward or their unequivocal acceptance as equals within a medically dominated health care team (Christie, 1995, Allen, 1995).

To date, nurses have succeeded in creating and developing much needed knowledge and skills largely because of their ability to "co-operate and compromise" (Moccia, 1990: 609). However, there are difficulties inherent in trying to define the future role of nurses when they are "attempting to maintain an effective nursing service in an environment that presents a vagueness of role, functions and professional parameters", not really knowing what constitute areas of legitimate clinical freedom and practice (Bowman, 1995:10). Lack of clarity in management roles (and subsequent problems in care management) have also been considered as priority issues by British health policymakers (Audit Commission, 1992). Even though in the UK the introduction of supernumerary status for nursing students was supposed to resolve the acknowledged *learner/worker dichotomy* (described by Melia, 1987), concerns continue to be expressed regarding a perceived shortage of experienced and appropriately skilled nurses available to "supervise, teach and counsel learners". There "continue to be many shortcomings in the way learners are developed" (Bowman, 1995:11). The argument that the continuing extension of nursing into delegated technical functions "splitting off fragments of care" is emotive, contentious and potentially of great importance to the way nursing will be learned in the future, the danger being that if this trend continues "what used to be known as nursing will be lost forever" (McMahon, 1992: 166).

A failure to adequately define and delineate the future roles and functions of the nurse and the doctor will inevitably lead to ethical problems, and further contention over who is capable of teaching what and why. Concurrent issues over the changing roles and responsibilities of junior doctors vis a vis nurses are a continuing source of angst and challenge to educational reformers, with some nursing leaders enthusiastically advocating far-reaching and definitive changes, not all of which appear to have been rigorously tested or thought through (e.g. Castledine, 1996).

As Hunt & Wainwright have observed, a wind of change is blowing across nursing here in the UK and Europe: "Where this wind blows and whether nursing should sail with it or tack against it are still not clear. What is growing clear is that nursing will become more diversified in character, less monolithic and more specialised than before" (Hunt & Wainwright, 1994: x).

It could reasonably be deduced therefore that shortcomings identified for students could legitimately be assumed to impact on the learner who then becomes the newly qualified or newly appointed member of staff, so that problems left unresolved in pre-registration education are likely to be compounded once the beginner enters clinical practice.

By failing to pay more than lip service to lessons learned elsewhere, nursing reforms could be accused of merely decanting "old wine into new bottles" (Myles, 1995). This was certainly the experience in North America in the 1970s, (Benner & Benner, 1979), and it is becoming more apparent here in the UK as nursing and medical staff shortages which were not envisaged at the introduction of Project 2000 educational reforms in 1986 now make themselves felt to nurse recruiters and service managers alike (e.g. Audit Commission report on Accident & Emergency services, 1996, see also Bosanquet & Gerard, 1989).

In 1992 when the current study was in its early planning stages, the mood among nurse managers appeared to be one of cautious optimism, with senior nurses envisaging a proactive role in the future deliberation of nursing issues and strategies similar in kind to that enjoyed by their colleagues in North America (e.g. Marquis & Huston, 1992).

The issue of professionalization had already been acknowledged as being responsible for creating an ideological ambivalence in nursing staff as to beliefs about what should and what could be perceived as the nursing role.

Nowhere was this to be felt more keenly than in the frustrations of those nurses who embraced the new managerialist ethos within the NHS, only to find themselves isolated and marginalised from the real seats of power. In assessing the impact of management reforms on the NHS's "professional providers" i.e. doctors and nurses, Klein (for example) has concluded that "Nurses quite clearly lost out: the effect of the Griffiths recommendations was that nurses lost both the right to be managed exclusively by a member of their own profession and their automatic representation on district management teams" (Klein, 1995:150). The shock waves of this were to be felt in the aggressive re-introduction of workforce planning, where issues of labour substitution and productivity began to replace the traditional focus on teamwork. As Stilwell has demonstrated, there are "immense methodological problems involved in measuring outputs when trying to evaluate labour cost-effectiveness in a systematic and rigorous way...." (Stilwell, 1992:85).

At the point in time when the present researcher was preparing to conduct the pilot study, nursing managers were busy grappling with these new requirements for managing nursing information and the nursing workforce.

A certain amount of tact and diplomacy was required to gain access to busy managers, particularly as there were internal managerial issues currently being worked through in their respective departments. Internal divisions and differences of opinion between managers were to be expected and were indeed experienced, but it was the largely unwitting and unfortunate researcher who was obliged to cross the fragile 'Magenot line' in search of information and clarification of issues [the Magenot line has been defined somewhat drily by the Concise Oxford Dictionary as " a line of defence on which one relies blindly", after A. Magenot, French minister of war].

Recognising that the sands were now shifting for nurse managers, and that this would have a bearing on their attitudes towards any prospective research study, the researcher therefore approached tentatively, knowing that any opportunities for involvement would be the subject of much discussion and negotiation. Given the internal competition between directorates created by the NHS organisational reforms, there was also the possibility that some managers might identify and seize on perceived opportunities for any credit or positive publicity arising from involvement in the research process. Klein has retrospectively touched on what was evident then: "that jobs had to be found for dispossessed nurse managers and [that] quite a few of them re-emerged in charge of quality assurance" (Klein, 1995:151).

The key to obtaining access therefore lay in appealing to nurse managers' sense of quality assurance. How would the proposed study impact on the quality of care offered by their unit/s? What were the likely costs/benefits involved? How could the research be managed in such a way as to help managers in their quest for better care and higher staff morale, and how could it be achieved with as little disruption as possible to everyday care-giving activities?

Finally, how might all of this be devised without compromising on the standards required of ethical research practice? To date, the literature was unclear as to the central concepts underpinning preceptorship. A preliminary conceptual framework had to be devised, together with some idea of how the data would be collected, processed, analysed and refined. The likely timescale and the exact nature of the staff's involvement throughout the research process had to be assessed. The contribution and stance of the researcher had to be made clear to participants so that any discussion concerning their own involvement could be discussed in relation to mutual expectations. A Delphi study which consulted a representative sample of 'experts' on the subject of new role learning was the ideal starting point for the study. However, the problem remained that few experts in this area could be identified, and those who could be were already accessible via a search of the relevant literature. What was needed was a much more pragmatic account of the problems confronting fledgling practitioners. It therefore seemed reasonable to target those closest to the experience, i.e. those recently qualified and those whose responsibility it was to see that they were supported in the process, their direct 'line' managers and staff assigned to oversee their induction to the clinical area. A decision was therefore made to conduct a pilot study in order to refine and organise methodology and to establish a framework and timescale for collaborative intervention.

Conduct of the pilot study

At this stage of the research process no decision had yet been made about specific methods to be employed in the main study. This was for two reasons, beginning with the need to determine the possible scale of the problem which was as yet unknown.

Secondly, it was not yet clear as to whether the researcher would be welcome in the workplace, given the very demanding work undertaken by staff, and their perceptions regarding the status of researchers. Reluctance on the part of the researcher to be imposed on participants was the only guiding principle at this early stage. The fact that the researcher was already employed within the Health Authority overcame the customary hurdles of 'who is she anyway?' and 'what business does she have here?', but this still did not give the researcher the permission or licence to make demands on staff which were outside their immediate control or abilities to respond. Having been appointed to her current post by the nurse director of the hospital (later NHS Trust) conveyed an indirect position of clinical leadership which had immediate implications for the relationship between the researcher and those who might be approached to participate in the study. This made the initial contact with participants in the pilot study geographically straightforward, but added a dimension to the study which was to be sensitive throughout. Whose priorities came first, the educator or the service manager, and who was the 'giver' and the 'receiver' here? What goods - if any - were likely to be exchanged in the proposed research bargain, and who would be accountable for any perceived lapse in that bargain?

The *education-service divide* which had been "blamed for the cavern between the educational curriculum and the curriculum of practice into which the taught attitudes had fallen" (Mingay, 1993:35) was about to be collided with 'head-on'. Whose fault would it be if the outcomes of the research did not conform to expectations, and what would be the potential price to be paid for it? Early and effective precautions had to be taken to see that any commitment of resources and participation could legitimately be accounted for.

Although it has been argued that the Delphi method "encourages honest opinion which is free from peer group pressure" (Williams & Webb, 1994:181) this did seem a somewhat treacherous pursuit for the beginning researcher who was relatively new in post and only beginning to get to grips with local politics and persona.

Proceeding with caution, therefore, three nurse managers were identified (all of them known to the researcher as colleagues and all of whom shared the same 'clinical grade' i.e. appointment as Senior Nurse, grade I with the researcher), therefore avoiding any potential conflict of hierarchy within the organisational setting. Two staff nurses were also identified and approached at the pilot stage. Both had been qualified and employed for a period of less than two years, although one worked at the minimum clinical grade 'D', while the second was appointed as the more senior level of 'E' grade.

In terms of *sampling* therefore, the pilot study could be described as *purposive*, in that the sample was hand-picked and supposedly typical of 'cases'; of *convenience*, in that participants were readily accessible; and *stratified* in that they represented certain specified groups within the given population of nurse managers and junior nursing staff (after Cohen & Manion, 1989:101).

Some consideration was given in the initial stages as to the possibility of conducting the fieldwork in a similar setting elsewhere, away from any potential internal or political problems. However, as part of the researcher's employment remit was to encourage research awareness and to promote research-based care, this was rejected from the outset, the fact remaining that support policies had to be introduced to the hospitals anyway.

It therefore seemed unnecessarily churlish to take the initiative elsewhere. This was probably a key factor in deciding to opt for a collaborative approach to the study, so that an additional agenda of promoting 'research-mindedness' was followed. This aspect of the study had interesting pay-offs for many participants, not least in terms of future career opportunities such as improvements in promotion prospects for co-researchers and an increased enthusiasm for pursuing further academic studies.

Aims of the pilot study

The main aims of the pilot study from the primary researcher's perspective were to:

- gain access to the field;
- establish some idea of the nature and scale of the problem to be studied;
- assess the relative importance and personal significance of the problem as perceived by pilot study participants;
- acquire a 'feel' for any core concepts or constructs which might usefully inform the study and its proposed vocabulary;
- probe the individual's own experience of learning support in the workplace;
- assess the overall feasibility of the study in terms of access, resources and likely strategic support from participants;
- derive some ideas as to the most appropriate methods to be used, so that the principle of collaboration could be made meaningful to co-researchers and their colleagues

Sensitivity to 'explanations'

'Explanation' can mean many things. As Antaki has suggested, different researchers will have "different ways of netting explanations and different ways of making sense of their catch. The differences among researchers are not just in what they think about explanations, but also in what they think about people and how they ought to be studied" (Antaki, 1988:1). The researcher's own concerns at the pilot study stage were to avoid the defensiveness seen elsewhere in terms of methodological correctness. Appleton (1995) for example has pronounced that if qualitative research "is to stand up to the constant barrages of positivist thinkers qualitative researchers must be clear about how they address issues of reliability and validity within their research studies. If this is not done we may fall into the trap of not being able to justify our proposed methodologies to positivist investigators and omnipotent scientific funding and research committees" (Appleton, 1995: 993). But, as Avis has concluded, constructive discussion about the whole problem of validity needs a critical examination of ways in which the "truth" of an empirical account can be conceptualized. He argues that validity is an epistemological concept "whose application depends on some fundamental positions taken about the nature of truth, representation and scientific methodology" (Avis, 1995:1206). Entrenched positivist/non-positivist distinctions he says therefore enforce the attribution of certain characteristics to either side of what he implies is rather a futile debate, which only succeeds in obscuring questions of representation. This is reflected in the nursing research literature which appears to be polarized into two camps, those which try to satisfy the positivist demand for 'hard' science, and those who reject this, preferring to make claims for the superiority of naturalistic inquiry.

This confusion is arguably made worse by attempts by authors and researchers (of a third, hitherto unidentified camp?) who seek to gain the stamp of positivist approval by adopting the language, but not the spirit or ethos of scientific method, the outcomes of which are muddling and disabling to those attempting to extract useful examples of good practice from their studies.

The present researcher was grateful for the pragmatic attitude adopted by educationalists who - on paper at least - worry less about appearances, and more about the impact of methods on the kind of data being produced. Hitchcock & Hughes, for example, tackle the subject in a reassuring manner when they assert "that interviews have been used extensively across all disciplines of the social sciences and in educational research as a key technique in data collection" (Hitchcock & Hughes, 1989: 79). Pilot studies are after all intended to provide an opportunity to 'test the water' empirically speaking, so that the feasibility of a method or overall framework may be assessed both for its strengths and weaknesses, and so that any obvious logistical problems can be identified and dealt with from the outset. Or, as Clark & Causer have put it, so that ideas may be 'test-driven' prior to carrying out the main research.

As these authors have warned, feasibility in constructing a research design is vital; issues of constraint and resource availability must be taken into consideration. They go so far as to suggest that the reason why a proportion of research students fail to complete their theses in good time is because the project or research design is too ambitious (Clark & Causer, 1991: 170).

Phillips and Pugh rely on a similar analogy when they say that students must demonstrate sufficient command of their vehicle - their thesis - when they utilise professional judgement and the proper evaluation of background theory. A failure to do so "would be the equivalent of your taking a driving test and driving at no more than 20mph throughout. You would fail because you had not demonstrated sufficient confidence and competence to be in charge of the vehicle" (Phillips & Pugh, 1987:54). In determining the present research design, therefore, the pilot study process was the material equivalent of assessing the driving conditions on the metaphorical road ahead.

The pilot study was small-scale in that five interviews were conducted, three 1:1 interviews with nurse manager colleagues in their own offices, and two 1 hour long meetings with two staff nurses in an office adjacent to the wards in which they were working. Structured interviews have been criticized by some qualitative researchers for not being sensitive enough and sufficiently flexible to respond to the real world and its attendant social contexts. Hitchcock & Hughes believe that this has much to do with underlying assumptions about the nature of the social world and the characteristics of interpretive research (Hitchcock & Hughes, 1989).

A common plea in qualitative research is the apparent need of the researcher to learn the language and rituals of the informants (Hardey, 1994:63). This is particularly true of studies which attempt to 'get beneath the skin' of a phenomenon, such as ethnography and phenomenology. Given the present researcher's earlier assertion that the present study is philosophically inspired by the perspective of 'social constructionism', it was reasonable to suppose that the pilot interviews and resulting data should be analysed on the basis of *deconstructionism*, or what Burman has referred to as *the identification and evaluation of guiding themes or discourses which structure dominant forms* (Burman, 1994:1).

Burman's work on deconstructing developmental psychology is powerful in its dexterity in that it has successfully employed deconstructionism, "not as a formal analytical framework but rather to indicate a process of critique" (ibid). The dominant forms under scrutiny in the present study were those assumptions and practices concerning learning in the workplace, the personal and interpersonal processes of becoming a qualified and accountable practitioner, and the rituals surrounding career transitions and, where possible, their attendant emotional impact.

The first step came in attempting to identify from the perspective of pilot study participants the *relative importance* (i.e. personal significance) attached to the idea of preceptorship, both from a personal point of view, and in relation to each individual's perceived position in the workplace. Constructionist analysis may challenge the ontological status of institutionally recognised and sanctioned phenomena to ask "what is the basis of the claim that the phenomena exist at all"? (Sarbin & Kitsuse, 1994:11). As a form of critique, therefore, it could be used to examine the nature of the described phenomena, and the meanings or significance attached to them within a given culture. Thus the research question is equally at home within the contexts of ethnographic and phenomenological methodology.

Ethnography has been defined as "a means of gaining access to the [...] beliefs and practices of a culture", the goal of the ethnographer being to "examine the native's view". Descriptive ethnography in particular "sets out to identify the social complexities that lie beneath the surface of a society" (Field & Morse, 1985:21/22).

In arriving at a description of ethnography as a method, Hammersley (1990) summarises the necessary characteristics as studying people in everyday (rather than experimental) conditions; gathering data from a range of sources (mainly observation and relatively informal conversations); approaching data collection in an unstructured way (i.e. not slavishly to a detailed plan), and focusing on a small scale or case study sample. In ethnography "the analysis of the data involves interpretation of the meanings and functions of human actions and mainly takes the form of verbal descriptions and explanations, with quantification and statistical analysis playing a subordinate role at most" (Hammersley, 1990:2).

Phenomenologists, following on from a movement associated with the philosopher Husserl, came about as a response to "the move by scientists to objectify human behaviour", whereby the assumption that humans could be predicted and controlled in the same way as natural phenomena was challenged and found wanting (Field & Morse, 1985:28). Hermeneutic phenomenology (associated with the work of Heidegger) is concerned with "interpreting concealed meanings in phenomena", thus the purpose of a phenomenological interview "is not to explain, predict or generate theory, but to understand shared meanings by drawing from the respondent a vivid picture of the lived experience, complete with the richness of detail and context that shape the experience. This phenomenological approach to interviewing blends listening and narratives" (Sorrell & Redmond, 1995:1120). It is difficult at first glance to appreciate the distinctions between the two approaches to yielding descriptive data. Holland (1993) claims that in ethnography the researcher's data collection is dependent upon his/her integration into the culture being studied, so that the ethnographer is as much a part of the data as other participants (Holland, 1993:1464-5).

Sorrell & Redmond describe the researcher's role in phenomenology differently, in that the role of the interviewer is to "gain insight into the 'inside-out' experience of the respondent through an engaged, profound approach to listening", such "active listening" shaping the interviewer's interpretation of what is actually happening during the interview (Sorrell & Redmond, 1995:1120). It could therefore be argued that the distinction between the two lies in the extent to which participants are "listened to" rather than *joined* in the processes of evaluation by the researcher. This was an important point to establish at the early stages, as the proposed data collection methods for the main study would need to be discussed and evaluated both for their efficacy and practical feasibility.

From the point of view of those interviewed at the pilot stage, several possibilities had to be explored. These centred on the following questions:

1. *What was the individual's experience of 'reality shock'?*
2. *Was the concept of 'career transition' a suitable basis for exploring phenomena associated with preceptor support?*
3. *How might staff be encouraged to explore these phenomena in more detail in relation to their personal and professional 'selves' and discourses?*

Each interview was guided by these questions, even though the means of arriving at them was different in each case. This process was affected by how well the participants knew the researcher (or thought they did!), and by the activities going on in the wards and departments close by the rooms in which the interviews were conducted.

Appreciating the need to be both approachable and considerate to the demands being made on the participants, attempts to remain friendly and informal were occasionally countered by a quizzical "you're not what I expected" from interviewees. This was a helpful clue to the researcher as to the stance anticipated from her in the future, and in each case participants were asked to elaborate on their "expectations" if they wished to - which they invariably did!

Process recording

Interviews were conducted in private, although occasional interruptions occurred because an immediate response to clinical or management problems was required. Questions and responses were recorded in speedwriting (a form of shorthand acquired by the researcher during earlier training as a journalist) in a university hardback A4 notebook and later transcribed for future perusal and checking by respondents as required. Queries and notes suggesting the need for further elaboration and clarification were recorded in the right hand margin of the page, together with occasional 'mind maps' and 'memos' drawn or written by the researcher during the analytic process.

Emerging data

The data which emerged from the interviews established that the need for the study was greater than the researcher had perhaps appreciated. UKCC recommendations on the provision of support roles in clinical practice had filtered down to participants, but had left them feeling rather confused regarding the application of such ideas in practice.

The new recommendations were generally perceived as "yet something else" to be concerned about, with some disillusionment being expressed about the efficacy of any new support arrangement "when the old ones hadn't worked". Each participant was able to describe their own personal experience of being newly qualified and/or new in post, and each expressed an enthusiasm for *any* support which might be made available to them. One area which the researcher had not given priority to before the Delphi study was the part played by 'significant others' in the support/ learning process. The existence (or lack) of supporters had been identified, but the ability of new practitioners to identify between those supporters who had a positive or negative impact on their personal and professional development had not been a particular focus. The data supported the view that a collaborative approach would be helpful from the perspective of both managers and staff.

The managers' concerns

Managers energetically supported any move which would help to bring about more cohesive teamwork, although one manager expressed concern that more senior staff could not be expected to spend too much time with the newly qualified person at the expense of more pressing concerns in patient care or management. All three managers were concerned about the strategic operation of support role implementation, and about the 'time out' required by supporters to prepare them for formal support roles. It was made explicit to the researcher at that time that their interest and support for the study would be conditional upon approving the amount of time available for preparation as participants and any onward commitment to the functions included within the partnerships. Greater clarity was needed in defining the criteria for staff acting as supporters; in particular whether the supporter/preceptor within the support partnership was required to have the national board qualification in teaching and assessing in practice.

Those with such expertise were "already overloaded" the researcher was told, and could not necessarily be relied upon to fulfil more commitments. Two managers requested information on the exact level of involvement to be undertaken by staff participating in the study, while the third requested regular briefings via a newsletter or similar, so that modifications or logistical changes in the study could be easily communicated and shared by staff. The concept of '*career transition*' was enthusiastically embraced, with the view being expressed that "managers need support, too". The implication here was that if preceptorship was found to be "cost-effective" and "really useful", then some way of addressing the problem for staff at other stages in their careers might also be sought from the researcher.

One manager described their own position as "misunderstood" by staff, so that "they wouldn't expect to get support from me for this project". Another expressed the wish to be "kept out" of the study as they felt they would be "tempted to interfere with the process if it didn't seem to be going right". All three managers were sceptical about the long-term prospects for the study, the consensus appearing to be that "like everything else, some people will soon lose interest". One manager did, however, stress that whilst this might be the case, it was "still no reason not to go ahead [sic]", and that some attempt at fulfilling the new support requirement had to be made regardless of any proposed research.

The staff nurses' perspective

Guiding themes and discourses which informed the data from the staff nurses were qualitatively different from those obtained from their managers. Here the 'dominant forms' represented the structures and influences affecting the process of '*becoming accountable*' and '*being held responsible*' for what went on in their wards and in the care of patients.

The perceived difference lay in "not being allowed to make mistakes like a student would", in "knowing who to go to" for help or guidance; in not "feeling stupid" or "forgetting something" which others considered important. They also felt torn between caring for patients and the need to help and guide students and other professionals on the ward. Relatives' information and support needs also demanded much of their time. The researcher perceived a guilty feeling on the part of the staff nurses for not having more time to support others, when in fact what the study was aiming at was an appreciation of *their support needs*.

It soon became clear that their 'critical consciousness' about obligations to others within the team and under their care was acute, at times threatening to blind them to the fact that they too were vulnerable. When asked to describe their own transitions into work, they were both keen to praise colleagues on the ward for their help in the process; and both were reluctant to imply any criticism of colleagues for failing to support them adequately. When asked if they felt "well supported" they said yes, a response the researcher had not really anticipated. What was hard to deduce was the extent to which they did not wish to be disloyal to their colleagues (and particularly their ward manager), and the extent to which they had already adapted to new demands being placed on them.

It was possible that they had been well supported in their transition, and that therefore the question of *adaptation* - and its processes - should be the focus of the study's attention. Key concepts which emerged were "adjustment" and "coping"; "getting on with it", "looking out for each other" and "learning the ropes".

Melia's classic study on the occupational socialisation of nurses had already made clear the tension felt between the demands of education and those of being a 'worker' in pre-registration, traditionally prepared students (Melia, 1987). It was becoming clear that in order to gain insight into how informal learning support was already operating in the workplace *for this new study*, some group activity which attempted to question how the adoption of certain attitudes and functional norms came about was necessary. Some kind of comparative analysis of material was also required in order to identify common themes and narratives and the reasoning which led to them, both individually and collectively.

Pilot study results

The pilot study had thus provided some reassurance to the researcher that the issue of transitional learning was in fact researchable; that discourses affecting the process were clearly to be found in the workplace and that access to these was not going to prove outwardly difficult or problematic. The notion that staff should "work through something together" rather than in isolation from each other was clearly apparent.

Thought therefore had to be given to the means by which staff could expect to approach the study, and it is here that Action Research (AR) came into view as the most helpful strategy for the implementation of preceptorship. The study needed to develop bilaterally, in as much as there were two identifiable strands to the work, namely *policy implementation* (i.e. the practical introduction and management of preceptorship); and *process evaluation* (i.e. an analysis and synthesis of the perceived impact of preceptorship on emerging support needs). Special care had to be taken to see that the study did not *in itself generate a demand for social support which had not existed previously*.

The main objective of the study was, after all, to gain new insights into adult learning processes and any emotional underpinnings which existed in relation to those processes. It was not to foist unwanted support on to a population which had no apparent need for it. It was therefore important to bear in mind that the model of preceptorship offered to staff might be rejected by staff in ways as yet unclear to the researcher. The pilot study had indicated that support in some form was needed, but had not been able to elaborate on exactly the form this should take. The study itself clearly fitted into the outline criteria characteristic of AR in that it could be practitioner-generated and workplace oriented; that it sought to improve a particular situation and that a trial and error approach was possible.

Equally well, it was possible to accept that the study would not be able to supply any definitive answers to problems experienced, save the proviso that it "aim[ed] to validate any claims that it ma[de] by rigorous justification processes" (McNiff et al, 1992:3).

Given the potential wealth of data which could amass from the study it was obvious that the dual processes of implementation and evaluation would require the intensive support and expertise of others in addition to that of the present researcher. Even if the new model of support was to be introduced in only one clinical area, assistance would be needed to formulate responses to emerging problems and the search for possible solutions. It was unlikely that a lone part-time researcher would succeed in meeting these demands. Consideration was therefore given to the possibility of engaging additional 'fieldworkers' as key participants, to oversee the implementation process and to act as a communication link between the primary researcher and co-researchers working in the 'field'.

This did not negate direct contact between the two as will be discussed in more detail later. Rather, it allowed more experienced staff to adopt an advisory role which gave all participants a sense of overall control and security in the research process which the researcher believes - in retrospect- was absolutely critical to the study's ultimate success.

Sample size

At this early stage of the study it was envisaged that the overall sample would amount to about 30 individuals. In the final analysis, however, the sample accrued no less than 284 participants across a range of employers and clinical specialisms, many of whom are still actively involved in implementing and refining the preceptorship model proposed by the researcher some four and a half years after its initial instigation. The geographical spread and increase in size of the sample was probably due mainly to the high profile given to the research by the regional nursing directorate, and partly to the emphasis placed on the issue by the official guidance given to employers by the UKCC. The research allowed employers who had as yet made little provision in this area to claim involvement in support initiatives at a mutually convenient and strategic level.

Data gathering: techniques and sources

An analysis of the key themes and narratives which emerged follows in Chapter 6. Before going on to examine how the model was implemented and the problems which emerged during data collection and subsequent analysis, consideration is now given to the methods for collecting and processing data. The table (Fig.1, p.102) provides an overview of the methods employed.

Not all of these methods were used throughout the study, and it has to be said that some were more successful than others in terms of data production and 'manageability'. The table is provided here to serve as an overview. Fig.2 (p.103) provides details of the written and experiential sources of data used by co-researchers in the development of preceptorship theory as it emerged over the three year period. For the purposes of the present chapter it is again important to present an overview of all methods tried in order to give some idea of the scale, breadth and depth of the study undertaken.

The next chapter explains how preceptorship was implemented in practice and discusses some of the strategic issues and challenges which had to be overcome in order to facilitate both policy implementation and the action research process.

Fig.1

DATA GATHERING (Methods and Techniques)

- **Modified Delphi study of staff qualified within previous two years + service managers**
- **Local investigation and consultation regarding existing support networks to establish local needs and priorities**
- **Values clarification exercises carried out in focus groups (both large and small) over two day experiential workshops**
- **Content analysis of critical incident reports undertaken as part of the workshops and preceptorship discussions in the workplace**
- **Concept and construct analysis in individual and group activities (including 'Socratic Questioning')**
- **Discourse analysis based on transcripts of group and 1:1 interviews, preceptor support and progress meetings, development of workplace learning support 'philosophies'**
- **Setting up and maintenance of Learning Contracts between preceptors and preceptees for the duration of the formal support period**
- **Identification of learning needs of both parties via local negotiation and the use of workplace portfolios and reflective 'practice based' diaries**
- **Problem-solving via negotiation, link preceptor and service managers' involvement assisted by documentation specially designed for the project**
- **Modification of the transitional learning support system via feedback on perceived strengths and weaknesses**
- **The use of 'analytic memos' as a record for the researcher in order to assist in the collection, analysis and subsequent interpretation of data and theory generation.**

Fig. 2 Data Sources used in the Study

Primary

Process documentation:

individual learning contracts between preceptor and preceptee, preceptee records, evaluation meetings, critical incident records, modifications to pilot documentation

Diaries kept by preceptors and preceptees

Records kept by 'link' or Unit Preceptors attached to different clinical areas

Minutes of meetings/outcomes/issues raised by preceptor support groups

Pilot study interviews

1:1 interviews with preceptor pairs

Records of 'troubleshooting' sessions in the workplace

Flipcharts from the Socratic workshops/focus groups

Formal Evaluations from workshops

Documentary evidence from meetings with managers and 'significant' others

Communications across all five sites used in the study (community as well as acute sector)

Minutes and notes from meetings with Trust director re access and setting up

Meetings and responses from statutory bodies/funding body

Policy and working definitions documents arising

Project reports to management on continuing education initiative

Input and policy reviews from ward managers and specialist nurses

Records held by individual departments/directorates

Secondary

Articles/editorials in the nursing media

Journal articles

Policy documents from UKCC and National Boards

Communications re region-wide initiative

Open learning materials on preceptorship (design and consultation)

Meetings with academic heads of colleges re policy developments

Changes to national policy arising from the present study

External communications/input from other public and private sector employers

Regional nurse director input (funding and strategic support)

Input from colleges of nursing and midwifery

Essays/articles written by participants for assessment and/or publication related to preceptorship and as an outcome of the present study.

CHAPTER FOUR

Methodology in Action

A description and explanation of the tasks involved in bringing the study together is given here in order to place the study firmly in context. As Schratz & Walker advise, it is important to describe research "in action rather than in abstraction", and to avoid presenting work as a "disembodied account of events" (Schratz & Walker, 1995:14).

Confused and inadequate terminology with regard to support concepts was the first and most overwhelming problem to be overcome in the introduction of preceptorship to the workplace. It was clear anecdotally that the workforce and policymakers approved of the principles of guidance and support, but that urgent in-depth analysis and clarification of support concepts was necessary to underpin practice and any theories which might emerge from that practice. Having identified the problem, it was now necessary to devise possible solutions, and to put in place the mechanisms required for clarifying the problems experienced and evaluating any action/intervention aimed at reducing them.

Key persons who could assist in the tasks associated with the AR process had to be identified and consulted, with a pooling of ideas as to the best and most credible way of implementing the proposed preceptorship support system. After initial consultation and discussion the following tasks emerged as being essential to the implementation process:

- * *Elaboration of support concepts so that working definitions could be used and refined in response to empirical findings*
- * *The formal introduction of preceptorship to the workplace, i.e. the setting up of preceptor pairs, together with some sort of qualitative monitoring;*
- * *The preparation of key participants/co-researchers;*
- * *The design and implementation of documentation and process management in order to record activity and guide the dual processes of support and AR feedback;*
- * *The provision of advice and support for pragmatic problem-solving at a partnership and strategic planning level.*
- * *Collection, storage, transcription, comparison and analysis of emerging data prior to synthesis and generation of any theory, followed by theory formulation.*
- * *A contextual review of the findings in relation to relevant audiences in education, health care and other human agencies;*
- * *Dissemination, continued praxis and publication as appropriate.*

Five site co-ordinators were identified and briefed as to the aims of the research study (known thereafter as ***Unit Preceptors***) according to criteria devised for the researcher's master's dissertation. These Unit Preceptors were then asked to trawl candidates for inclusion in the study from those employed within their own organisations who might be willing to act as ***Designated Preceptors*** to newly qualified or newly appointed staff allocated to them as part of the preceptorship process. Criteria governing their selection had also been devised previously following an extensive review of the relevant literature. Newly qualified staff (i.e. ***Preceptees***) were to be allocated to their designated preceptors after a short period of formal induction to the workplace (see Appendix pp.301-2).

Permission for staff to take time away from regular duties to collaborate in data collection and analysis had already been obtained in writing from participants' respective employers. All of what were now termed **Co-researchers** were briefed via a newsletter and face to face exploratory meetings with Unit Preceptors and the primary researcher, and provisions for the study's ethical management were put in place by a written letter from the researcher assuring co-researcher anonymity, and outlining their right to withdraw at any stage from the study without the need to offer an explanation.

To begin with, the most time consuming task was the design and piloting of ward (or area) based documentation which would assist co-researchers in implementing appropriate and meaningful support at an interpersonal level, and yet at the same time yield valid data for inclusion in the study. Existing materials devised for previous support networks locally had signally failed to serve any purpose beyond that of mechanically recording and storing information, and so it was decided that an original framework would be devised based on the principles established for 'learning contracts'.

Documentation designed by the *Learning from Experience Trust* (Dearden, 1989) for use by employees was examined, and a draft document devised for use in the current study using some of the same principles. Interestingly, as the document was constantly re-evaluated and refined through the AR process what emerged is now barely recognisable as a learning contract. Nevertheless, the researcher feels it is important to acknowledge the use of existing formulations in the development of the 'tailor-made' version which has now become distinctive of the emergent preceptorship model.

Description of the proposed model

The initial model proposed represents a vital developmental stage in the evolution of the emergent model of preceptorship, having found its roots in the primary researcher's earlier MEd dissertation entitled '*An Evaluation of Preceptorship as an Appropriate Conceptual Model for British Continuing Nurse Education*' (Morton-Cooper, 1992). The scope and conclusions of the dissertation are outlined below.

Scope and conclusions/recommendations

- a conceptual analysis of the preceptor construct was undertaken following a literature review;
- problems were identified in attempting to transfer the established US preceptor concept to the UK because of existing support role terminology and confusion over interpretations of similar support roles here in the UK (e.g. mentor, clinical supervisor);
- a policy analysis revealed a lack of rigour from British statutory organisations regarding the conceptual analysis of preceptor constructs and the formulation of formal guidelines to support practice in this area;
- the researcher instead proposed a re-working of the concept to suit the UK scenario of peers, rather than the North American model of student/staff nurse and faculty instructor triad;
- preceptorship was also examined as to the likelihood of maintaining concept stability in the light of continuing reforms in nursing education and practice;
- a philosophical and theoretical framework for a new model was proposed with a view to it being empirically tested via a part-time research degree.

Working definitions

As no standard UK definitions existed at the start of the present study, the primary researcher volunteered working definitions based on the literature and adapted to suit British *post* rather than pre-registration practice. These definitions were refined several times over the period of data collection and constant comparative analysis. The critical distinction between the established role of mentor and the proposed new role of preceptor here in the UK was drawn by defining **mentorship** as *career socialisation*, and **preceptorship** as *clinical socialisation* (after Morton-Cooper & Palmer, 1993).

A suggested definition of the term preceptor was offered by the researcher to senior educationalists in the West Midlands region and was later used throughout the study.

A preceptor was therefore defined as:

"a qualified and experienced first level nurse who has agreed to work in partnership with a (newly) registered practitioner colleague in order to assist and support them in the process of learning and adaptation to his or her new role"

(WMRHA paper, April, 1993)

For the purposes of collaborative action research evaluation the study was divided into the two discrete but complementary strands mentioned in Chapter Three, i.e

1. **Policy Implementation** (i.e. the practical introduction and management of preceptorship in each clinical area), and
2. **Process Evaluation** (i.e. an analysis and synthesis of the perceived impact of preceptorship on emerging staff support and development needs).

A wide range of tasks were involved in the evaluation, and important decisions had to be made at an early stage as to who would be responsible for particular aspects of the data collection and management. Had the study been conducted as an experiment the sample would not have been able to expand as it did, as most of the tasks and associated recording of information would have fallen to the primary researcher to complete. However, the collaborative nature of the study presented the opportunity to validate the model through practice, allowing groups and individuals to participate in data collection and analysis over the initial three year period prior to writing up.

Key features and assumptions underpinning the proposed model

*The period of 1:1 preceptorship support was time limited and entered into on the basis of a partnership agreement between the designated preceptor and the preceptee (usually four -six months) and involved regular meetings (usually weekly) on the ward or unit participating in the study;

* The relationship differed from North American models of preceptorship in that it was intended to be non-hierarchical, i.e. a peer relationship between qualified staff, rather than a pre-registration model of preceptor and nursing student;

* The relationship was evaluated (primarily, but not exclusively) on the basis of the perceived *quality of emotional support* between the two parties, and therefore would be different from previous instructional, didactic methods in that it would be *process* rather than outcomes based;

* The partnership would be overseen by a third party - the Unit Preceptor - whose role it was to plan, document and manage the strategic implementation of the preceptorship process across the workplace.

Limits to Collaboration

Collaboration necessarily involves working with people who may not share the same world views regarding the purpose and value of research work, and it was important for the primary researcher to recognise early on that a range of views and perspectives would inform the collaborative research process. The possibility of a practice-based theory emerging from the study was tantalizing to the researcher, but recognised as potentially contentious for those whose previous experience of research had been submerged within a positivistic framework.

However, Denzin & Lincoln (1994:2) present a comforting and helpful metaphor of the researcher-as-*bricoleur*, drawing on the work of Levi-Strauss and Becker. "The bricoleur produces a bricolage, that is, a pieced together, close-knit set of practices that provide solutions to a problem in a concrete situation". The bricolage is necessarily an emergent construction drawing on pragmatic, self-reflexive and strategic methods, fitting in well with Denzin & Lincoln's conception of qualitative research:

" Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.....Accordingly, qualitative researchers deploy a wide range of interconnected methods, hoping always to get a better fix on the subject matter at hand."

(Denzin & Lincoln, 1994: 2).

Reflective Diaries and Critical Incident Analysis

The conventional study of documentation in the learning support process (.i.e. reflective diaries completed by both preceptor and preceptee, problem-solving activities conducted in the workplace via 'critical incident' analysis (CIA) of both positive and negative learning experiences) would clearly provide potentially useful material as to the kinds of practice based learning which could be self-directed and peer validated in the workplace; but this in itself was unlikely to reveal the values underpinning the actions carried out. For the researcher, this would be 'third hand' knowledge which had previously been constructed and edited, rather than a 'flesh and blood' unexpurgated account of views and opinions on the process or the learning context.

Writers who have studied the psychology of diary keeping say that there has been little systematic attention paid to the educational or therapeutic use of assigned journals. They describe a diary as an object, a place and an activity, all of which can be used to define and manipulate 'boundaries' between people and situations. Diaries can be used to process emotional experience and to help individuals compartmentalise and separate between different aspects of their emotional lives: "Diaries can control and contain emotional experience in various ways, for instance, by evoking and shaping it in the act of writing" (Weiner & Rosenwald, 1993:38).

Nevertheless, journal writing has been said to help adults "break habitual modes of thinking, and change life direction through reflective withdrawal and re-entry" by being able to take a "step back" from an incident or conversation, to reflect upon it and to return to it with understanding and perhaps new insight (Lukinsky, 1990:213).

The process of critical reflection can also be assisted by the recognition and analysis of our collective assumptions, assumptions being defined as "those taken-for-granted ideas, common sense beliefs and self-evident rules of thumb that inform our thoughts and actions" (Brookfield, 1990:177). Critical incidents are "brief descriptions written by learners of significant events in their lives", and as such, they form a valuable part of any social learning process, and offer a means of "probing learners' assumptive worlds" (ibid:179).

Preceptor pairs therefore met regularly over the four month period of support, (usually at a prearranged place and time) to discuss mutual expectations of preceptor support, to complete learning contracts, identify and set learning goals, propose mutual strategies for meeting these and to reflect on and discuss examples of both good and bad (nursing) practice as experienced by the preceptee in the week or period of time prior to the meeting. Some preceptors preferred to work on the same shifts as their preceptees in order to allow the preceptee to rehearse certain skills. This proved to be problematic over time, however, as the vagaries of rota completion, sickness and holidays sometimes played havoc with their best laid plans. Formal documentation of these meetings was time consuming initially until each partner adjusted to what felt appropriate and manageable. The benefit of having a record to which both parties could refer did, however, prove vital as it enabled either party to keep abreast of developments at times outside of their regular meetings.

Taken together with semi-structured and unstructured interviews which focused on the preceptorship process, co-researcher diaries and critical incidents provided an evaluative framework for the present study which could be managed in the workplace with relative ease.

The recurring themes and narratives presented by them are the subject of Chapter 6 when the day to day experience of participants begins to inductively generate a collaborative theory of preceptorship. The ways in which theory developed is also discussed in detail in the final chapter of this thesis when it is necessary to make clear the links between theory and method.

Another pressing problem for the primary researcher in the early stages of the research was to find a method of critical and analytical groupwork which would throw further light on the 'assumptive worlds' of experienced, and *already socialised* members of staff. Those who had volunteered to act as *designated preceptors* had put themselves forward for a number of reasons, and it seemed reasonable to assume that (at least for some) their willingness to participate indicated an empathy for and identification with the perceived plight of the newly qualified. This could not be guaranteed, however, and so some exploratory groundwork needed to be undertaken to elucidate the designated preceptors anticipated value stance towards their proposed preceptees. It was here that the Socratic 'elenchus' offered a possible solution.

The Socratic Mission

Livingstone has described Greek ideals as indispensable to the spiritual life of our civilization, believing that modern crises are the result of a collapse of spiritual unity. He contends that "If our greatest needs are clear standards and a definite philosophy of life, [then] the classics can help us". He also feels that scholarship plays an invaluable part in the study of civilization and its malcontents (Livingstone, 1935:4).

Born the son of an Athenian stonemason in 469 B.C., Socrates is said to have come of age at a time when Greek philosophy was in full flower, and during a period when "practical human problems and questions of a philosophic, religious and ethical nature were raised and debated in dramatic form" (Sowerby, 1995:120). Sowerby reminds us that Socrates did not write anything down himself, so that our knowledge of him and his works depends chiefly on the study of works by the historian Xenophon (*Memoirs of Socrates*), and from the Socratic dialogues written by Socrates' pupil Plato, some time after Socrates' death by execution in 399 B.C. Disillusioned with the ignorance and apparent complacency of politicians and sages of his time, Socrates is reputed to have engaged in '*elenchos tou biou*' (hereafter referred to as 'elenchus') as the systematic "examination of life" through dialogue.

His one great philosophical question was 'What is the right way to live?' (Jordan, 1990:64). He is said to have differed from his predecessors in questioning whether virtue could be taught, arguing that the only claim to human wisdom comes from recognising the extent of our own ignorance (Perkinson, 1980). Socrates challenged the notion that man [sic] could be wise, saying that only God could be wise. His mission therefore was to seek out those who claimed to be wise, and to expose their ignorance for what it was. He did not profess to be a teacher or a leader as his forebears had done, but rather saw himself as a "fellow seeker after truth":

"His methods were revolutionary. He did not lecture, like the Sophists. He did not write books...Instead, he questioned people about what they thought they knew. In this questioning, speaking back and forth - "dialogue" - Socrates invented a method to analyze and clarify the meaning of fundamental value terms" (Ferre, 1996:41).

By patient questioning and examination of opinion for its logical consequences, Socrates sought consistency in fundamental definitions of meaning, hoping that this might help to clarify and address the ethical problems of the day. For Socrates then, "knowledge requires more than right opinion: it requires also that our opinions, even when correct, be further supported by some principled 'account' that shows why it is believed and must be so" (Ferre, 1996:45). Successful *elenchus* is thought, therefore, to increase our collective stock of true beliefs, by finding answers to those important questions which have practical implications for the everyday conduct of our lives (Jordan, 1990).

Gregory Vlastos, the distinguished though somewhat controversial 20th century classical scholar, believes that *elenchus* is essentially a method of philosophical investigation which exposes the inconsistencies of peoples' behaviour.

In Socrates' view consistency therefore sufficed for, or equated with 'truth' (Vlastos, 1991, 1994). Socrates is said to have believed in the improvement of the human soul, based on a strong personal conviction that "man is fallible [sic]; man intends to be good, but he fails because he is ignorant of what the good really is" (Perkinson, 1980:9) He was convinced that the critical exploration of values was the only way to uncover wrongs and to bring forth any possibility of putting them right. Despite outward negativism, it was thus possible to *imagine* progress.

In accord with the 'critical thinking' espoused by contemporary educationalists, he supported the view that an open society permits comprehensive criticism of its values via the establishment of a critical tradition (ibid: 12).

It is important to remember, however, that Socrates was considered by his contemporaries to be a political subversive who was eventually condemned by an Athenian court to be executed. He is said to have accepted this judgement on him willingly, recognising that what he saw as his divine mission would be fulfilled in demonstrating the weakness and folly of the Athenians by their condemnation of him. Even when offered the chance to escape by his friend Crito, Socrates refused, arguing that to do so would be morally indefensible (*Crito* 53a-54b [E]). It must be said that history has certainly treated Socrates with respect. Ferre, for example, describes him as "a fulcrum figure in the history of philosophy...like the figure whose celebrated birth in a manger still defines the calendar for much of the modern world, Socrates cared enough to die for his values" (Ferre, 1996:39).

Perkinson also affords him a full measure of Greek glory and heroism:

"By refusing to flee Athens, by allowing his fellow citizens to kill him, Socrates makes them aware that it is wrong to silence critics. A free society, an open society, must have critics and must protect them. Socrates' death remains one of the most poignant and at the same time most significant acts of teaching in the history of Western civilization" (Perkinson, 1980:13)

There are, of course, critics of the Socratic method. People may need more than the intellectual understanding provided by the elenchus to resolve their problems in living (Jordan, 1990). The Greek 'oracular injunction' to 'know thyself', Socrates' maxim that *the unexamined life is not worth living*, is very similar to the worldview of modern existentialists who see morality as heroic: "It takes courage to make our own rules and to stand by them regardless of others' opinions. The ability to choose, to make intelligent decisions is seen as a cardinal virtue by the Existentialists because the very idea of choice implies a certain conception of freedom" (Carlton, 1995:81).

Jordan cites Wittgenstein's quest for knowledge by paying reflective attention "to what people say", so that our knowledge is not bound solely by opinions, but also recognised for its contextuality. If we are after an improvement or insight into self-knowledge, then the elenchus may help us to live better. It has its limitations and its paradoxes, as Jordan explains. Socrates does not turn ignorance into knowledge, but rather turns supposed knowledge into ignorance, a thorny issue which is unlikely to win friends even if it ultimately does influence people (Jordan, 1990:64).

It is in this method of *refutation*, that the heart of Socrates critique of human nature lies. It may be that modern science has taken the challenge too literally, in seeing the answers to human problems in the supposed objectivity of empirical science, so that science has come to dominate arguments over what is morally right or wrong (Weatherall, 1995). There is nevertheless potential in utilising Socratic method via qualitative research in order to lay bare or illuminate the actions and belief systems of groups and individuals. For all its contradictions and frustrations, the elenchus still has the propensity to be helpful:

"It can lead to the undermining of existing theories, to greater epistemological caution, and towards the formulation of tentative new (as yet unrefuted) conjectures. One can hope, using this method, to formulate answers to the great questions of how we should live, and to the subsidiary questions of how to define the virtues. The hope will often be frustrated; and at best we will not know that we have achieved the right answers to these questions. But, as Socrates himself demonstrates, one may have a fair degree of subjective certainty about this, while recognising that one's beliefs are as yet only provisional"

(Jordan, 1990:69)

For the primary researcher, the challenge was to devise a way of conducting 'elenchus' which would be accessible and communicable to co-researchers without being off-putting, or imparting an 'ivory tower' feel to deliberations. The answer perhaps lay in the examination of how groups worked best, and it was to the literature on groupwork that the researcher now turned.

Qualitative Methods and Focus Group Work

Living and working together in groups is a fundamental element of human experience, and while work groups are not always appropriate for some tasks or functions, there is evidence that the introduction of group goals can lead to better productivity and improved organisational performance (West, 1996). However, there may be advantages and pitfalls in solving problems in groups, unless the group is clearly cohesive and committed to a course of action (Makin et al, 1996).

From a social constructionist perspective, members of small groups are natural social research actors in that they continually construct, deconstruct and reconstruct their social reality for themselves (Steyaert & Bouwen, 1994:123). Membership of what is collectively described as society therefore depends on the extent to which human beings construct, perceive and internalise the espoused values of a given community. People live by their definitions of shared situations and realities, so that they live not only in the same world, but participate in each others' being (Berger & Luckmann, 1966:150).

Socialization processes occur within organizations and work groups and they are thought to help individuals to recognise their roles and relative position in the organisational hierarchy. Nicholson has described *organizational socialization* as a key process in the differentiation of organizational and occupational structures, and has defined the socialization process as "the formal and informal social influence processes through which individuals acquire the skills, values and beliefs necessary for them to function as a member of the group or institution" (Nicholson, 1996:167). On the face of it, then, socialization is a useful concept with which to begin an examination of values in relation to preceptorship.

Given that occupational cultures are thought to generate their own norms and 'givens' in the workplace, there is some credence to be had in viewing socialization as the key process through which a desired change in social practices could be driven. Nicholson detects a trend in socialization research as moving away from the "traditional view of the individual as a malleable recipient of influence and towards a more active construction of individuals as agents of their own socialization". In any case, the impact of formal socialization processes (such as training, induction and supervision) is thought to have less material effect on individual attitudes than those informal influences operating at the level of peer groups (Louis et al quoted in Nicholson, 1996:168).

The bringing together of groups within the workplace who already have shared responsibility for reproducing (knowingly or otherwise!) the kind of socialization processes described above is therefore a potential powerhouse for generating practice based theory in relation to preceptorship. But it is vital not to neglect the pivotal importance of trust between co-researchers, so that role relationships must be made clear in any planned 'psychological contract' between those involved in collaborative enquiry.

The essence of the psychological, as opposed to economic, contract between persons is that expectations concern non-tangible, psychological issues; hence, the *psychological contract* relates more to promissory and reciprocal obligations between parties, the negation of which "may produce more emotional and extreme reactions than when weaker expectations are broken" (Robinson & Rousseau, 1994, Makin et al, 1996:50). All contracts involve exchange in one form or another (Makin et al, 1996), thus it could reasonably be argued that it was the exchange of time, energy, information, possible future gain and (in some cases) painful personal disclosure, which constituted the *implicit* psychological contract in the current study. Social constructionists might, however, argue that this is only one way of 'producing an account' of the relationship through language.

In assessing the gains to be had from the primary researcher's perspective, then, the value of undertaking Socratic inquiry had to be carefully balanced against the possible or likely costs to individuals or the organisations involved in the study. In particular, the interplay of focus group methodology and that of the 'elenchus' needed to be explored in some detail.

Focus groups

Focus group methodology is a specific, if underdeveloped, approach to group interviewing in the social sciences; its hallmark being "the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group" (Morgan, 1988:12). In a leading nursing research text, the method has been described as "an interview in which the respondents are a group of people assembled to address questions on a given topic, usually in a conversational, unstructured way" (Polit & Hungler, 1993:437).

This also gives researchers the opportunity to observe a good deal of social interaction in a limited period of time (Morgan, 1988), so that it could be described as an *intensive* method of data collection. A potential disadvantage of the method, however, lay in the time-consuming and laborious transcription of data which might not always be accurately or easily recorded using conventional tape recorders. As the core method for this study centred around the setting up of *exploratory experiential workshops*, (each of two working days' duration) with groups of between 12 and 28 participants, it was clearly impractical to consider the recording and transcription of 16-18 hours (160 in total) of group interaction.

A reliable method of data recording and processing had to be found which would be manageable in terms of handling and transcribing, and after discussion with the Unit Preceptors it was decided that the workshop would be led by two people, each of whom would take alternate 'sessions'. One leader would then be free to take notes during the discussion led by the other leader.

In addition, the workshop leaders and participants would each have access to a flip chart and pens which would enable them to record thoughts and arguments debated during the course of the workshop. Despite initial concerns, this method worked extremely well, as it not only provided easily read material for transcription, it was also possible to use the written materials at the end of the workshops as a mechanism for validating the data, with participants being able to 'track through' and confirm the 'data' as an accurate account of events. Participants were very comfortable with the flipchart method because of its familiarity in college settings and for its openness: or, as one participant described it, "no-one was scribbling secretly in a corner".

This appeared to add to the informal and relaxed atmosphere. In terms of data analysis, many of the concepts, ideas and (consequently) 'categories' which emerged were startlingly clear once charts from different sessions were later compared, even though they had been acquired in different settings by different groups. The major disadvantage of flipcharts lay in their storage - each site acquired large boxes of 'data'. It should also be remembered that this contributed to an already steady stream of data from reflective diaries, process documentation and 1:1 interviews to assess the quality of emotional support, all of which clamoured for attention.

Workshop format

Before going on to discuss the practical handling and management of the data, an outline of the workshops is given next, together with an explanation as to the use of 'Socratic Questioning' (as *elenchus* was 're-termed' for the study). Originally, only two workshops were envisaged as the initial cohort was to be limited to 15 designated preceptors and between 15-20 preceptees. However, due to the policy imperative on employers to prepare staff for preceptorship, and the enthusiastic support of individual participants, the impetus grew for more staff to become involved. The support and interest of the regional nurse director also led to the involvement of other NHS Trusts and health authorities. One of the first 'side effects' (to use the medical jargon) of the study was the increasing confidence of preceptors to seek promotion and to take on more responsibilities - particularly in relation to teaching and learning - hence staff turnover increased and more staff came forward to take part in the workshops. The subsequent 'halo' effect generated by the study is discussed in more detail later, but it is mentioned here in order to acknowledge its impact on the research process, and to indicate that co-researchers were aware of the phenomenon from an early stage.

Participation in the workshops was a prerequisite for those intending to offer formal learning support as Designated Preceptors. In the initial (acute sector) cohort this was made a condition for access to the research site, and while it is recognised that this could be seen as compelling participants to participate, in most cases participation in the study *per se* was entirely voluntary. Issues arising from the minority (c.10% of the sample, n =284) who were expected to attend because of "pressure" from their managers, are discussed with regard to the ethical management of the study later in Chapter 6.

As co-ordinators, Unit Preceptors assisted in planning the workshops and generally undertook the practical arrangements for booking suitable accommodation (usually on-site in college accommodation or health centres), contacting Designated Preceptors in the workplace, arranging access to canteen and other necessary facilities, and making sure that prospective participants had received the preparatory reading material and information in advance of the planned sessions.

Unit Preceptors were also consulted on the format of the workshops. An outline and constantly adapting framework drawn from the continuous process of literature review, debate and co-researcher analysis was synthesised by the primary researcher, and then refined by Designated Preceptors for use in local situations.

In general, therefore, the workshops followed the following format. Please see Fig. 1 below for a summary of the workshop content.

Fig.1 Summary of 2 day workshop content

Day One

Aims/methods of the study
 Developing a Support Network
 Discussion of assumptions and values
 Group Feedback and discussion
 Literature Review

Day Two

Introduction to the proposed model
 Establishing learning contracts
 Process evaluation and documentation
 Preceptor support networks
 Workshop evaluation

DAY ONE

9-10 a.m. Introductions/ Aims of the study

Unit Preceptors 'hosted' the workshops and led the introductions. The primary researcher expanded on the aims and answered questions from participants. Ground rules were set collaboratively for the sessions which would then be put in place for all subsequent workshops. These included confidentiality between participants, particularly regarding disclosures; the right to withdraw without comment, the right of access to written materials pertaining to the research, and the right to negotiate or express opinions on any matter pertaining to the research process. It was then explained to participants that they could choose to leave the sessions (without question) if they no longer wished to participate on those terms.

No participants chose to leave or withdraw at this stage, although it should be borne in mind that the alternative for them was to return directly to work, as they were currently taking up 'health authority time'; (again a condition of access).

Only four of those who attended the workshops eventually withdrew from the study; two to take up employment elsewhere, one to go on maternity leave, and a fourth to attend university full-time. It therefore remains difficult to assess whether the remainder stayed out of loyalty to the study, or because they preferred the 'time out' it offered to working a normal shift! Other, more subtle forms of pressure may also have been operating, such as peer pressure to conform/ participate, anxiety about being 'left behind' in the career stakes, or fear of jeopardising chances of promotion should they appear to hold back on a perceived high profile initiative.

10.30 -12.30pm. *Developing a Support Network.*

This part of the workshop entailed a reflective exercise, asking participants (working in small groups) to recall their early days after qualification, and to identify, retrospectively, their *significant others*; in particular those who had either 'helped or hindered' their adjustment to the role of qualified nurse.

Details were noted on flipcharts and (after coffee, and much hilarity and debate!) participants compared their replies in an open forum. The workshop leader then asked participants to consider the Socratic question '*What is the right way to live?*' i.e. they were asked to elaborate on the possible processes and cultural forces at work in bringing their own subjective experiences to bear on preceptor support. How had their situations come about, and what *values* did they appear to reflect on the part of *their* significant others? Given that, as designated preceptors, they were about to become a 'significant other' to a newly qualified or appointed member of staff, how did their current practice match up with their personal experience of learning support for beginning practice, and how (on reflection) might they approach the situation in future?

1-2p.m. *Assumptions and Values.*

This session was intended as an exploration of values in nursing work, and the possible relationship or perceived conflict between personal values and those evident in the workplace. The distinction between espoused values and behaviour was clarified, thus the Socratic *search for consistencies* was continued, with consideration being given to what might constitute 'active' and 'passive' role modelling. In particular, how might participants current practice or 'behaviour' appear to their preceptees, and what conscious efforts might be made by Designated Preceptors to see that values and behaviour matched? What did both parties expect from each other and what, realistically, might both parties do to overcome the likely constraints of time and pressures of work on their support relationship? What vocabulary was used in relation to beginning practice and what impact did this have on the integration and socialization of newcomers to the work group?

2.30-4.30p.m *Group feedback and discussion* (led by participants)

This session was the most challenging to facilitate as each group brought their own particular worries and concerns to the fore. Most anxieties seemed to focus on the preceptors' management of the documentation, so that the primary researcher and unit preceptors soon learned to refine the documentation accordingly. As a consequence later feedback sessions were able to devote more time to the ethical/hypothetical issues because early ambiguities and lack of clarity had been ironed out. Part of this session was also dedicated to discussing recent events or published work thought to be relevant to preceptorship (or research work), with individuals exchanging ideas (and arguments!) as to the best way forward.

DAY TWO

9-11a.m. Introduction to the proposed Preceptorship model

This session was led by the primary researcher and the Unit Preceptor/s. Views were requested as to the feasibility of such a model in day to day practice. What problems or issues might be anticipated and how might the support framework be adapted to address them? Discussion on adult learning processes usually emerged in this part of the session, as many participants had recently completed (or were planning to complete) a formal teaching certificate as National Board approved assessors of practice.

The decision to have Designated Preceptors who had had no formal preparation as 'teachers' was also discussed, the justification (arrived at in the selection criteria) being that the support process was emphatically about *providing emotional support*, not teaching as such. Preceptees could therefore be confident that the support process was *not* about *assessing performance*; a vital distinctive feature of the current model, and one which has since set it apart from other learning support models in nursing. However, staff nurses who had undertaken assessor's courses were not precluded from participation, and in the case of unit preceptors a formal assessor's or teaching qualification was indeed a prerequisite, largely to placate anticipated criticism from nurse educationalists for failing to recognise the teaching element of the preceptor role. (On reflection, the 'hidden agenda' behind this was probably to raise participants' awareness of their responsibility for creating a maintaining a supportive learning environment, rather than maintaining the prevailing view that this is the sole responsibility of nurse teachers and lecturers).

11-12.30p.m. *Establishing Learning Contracts*

This session was led by the Unit Preceptor for the hospital/centre and the principles of learning support contracts were explored. Process documentation emerged from the discussions which took place in early workshops and was subsequently refined following evaluative interviews (with preceptor 'pairs') and later discussions at preceptor support meetings.

1.30-2.30p.m. *Process Evaluation and Documentation*

This session addressed the practical implementation of the model within the collaborative action research cycle, with particular attention being paid to individual co-researcher's roles in data collection, feedback and process management. Ethical issues tended to surface here, as did discussions concerning 'troubleshooting'. These came to be known colloquially as the " 'what-if' sessions"!

2.45-3.45p.m. *Preceptor Support Networks*

Participants were asked to discuss and devise a support network (both formal and informal) which they believed might meet their own needs for continuing moral and practical/informational support. Unit preceptors then helped to plan and implement the formal network after further discussion on the practicalities with local managers.

In general, the formal support consisted of regular review meetings for designated preceptors, set up and attended by Unit preceptors who then fed back directly to the researcher. The researcher also attended early support group meetings (by invitation only!) but later refrained from doing so because it was felt that her presence tended to polarise the discussion into the positive rather than negative factors affecting implementation.

Support groups tended to be used for the airing of problems and feelings concerned with the day to day implementation of the model, and the researcher feared that participants might avoid raising contentious issues to avoid 'disappointing' or 'offending' her, or in some way jeopardising the project. By not attending the support sessions the discussions could therefore be conducted in private, so that although participants were asked to convey their emotional reactions and feelings to situations through normal written feedback, confidentiality could still be assured. This was particularly important in early workshops where the researcher was a member of staff and worked closely with senior managers on other projects. Later cohorts questioned this decision, and in fact the researcher did attend future sessions if participants were particularly concerned to have her present.

4-5.p.m *Evaluation.*

The final session was devoted to a formal evaluation of the workshop, when participants were asked to complete an evaluative (non-attributed) questionnaire on the proceedings, and on their perceptions of the feasibility of the study and their own anticipated part within it. As with other documentation, the opinions and suggestions derived from questionnaires were later transcribed and used for several purposes: first, to gauge initial feelings and perceptions about the study, and secondly to assess whether the researcher's interpretation of 'Socratic Questioning' had proved successful as an exploratory research tool.

An added bonus was that information trawled from these questionnaires helped Unit Preceptors to structure future workshops so that they were more sensitive to the particular needs of participants. In particular, it was found that more time needed to be devoted to structuring and piloting process documentation so that it could be utilised effectively in a work situation.

The Elenchus as a research tool

Story-telling is central to the development of our self-understanding, so that oral and written first-person stories can allow nurses to learn from their respective successes and failures:

"The practice of story-telling requires a climate of trust and disciplined attention to learning from experience, rather than focusing on grading academic performance. Since experiential learning always entails correcting, extending, or adding nuances to one's pre-understandings, the focus is on learning and change, rather than achievement. In clinical practice, the goal is to avoid as many mistakes as possible, and the ethical demand is that one learn[s] from one's own and others' mistakes". (Benner, Tanner & Chesla, 1996: 320-321).

The outward strength of the elenchus is therefore in providing a receptive forum for the re-telling of these "stories" in a non-judgmental and empathetic environment. Technically speaking, the elenchus means "*to examine, refute or put to shame*". It requires "at least two voices to be heard", and those voices must be "intimately connected with the positions they take". For Seeskin, elenchus is more than an exercise in philosophical analysis:

"... it asks people to state and defend the moral intuitions which underlie their way of life....[and] has as much to do with honesty, reasonableness and courage as it does with logical acumen: the honesty to say what one really thinks, the reasonableness to admit what one does not know, and the courage to continue the investigation" (Seeskin, 1987: 1-3)

Asking people to dispense with their normal psychological defence mechanisms (lies, rationalisations, euphemisms and excuses!) would seem to be a fairly risky pursuit for a researcher, especially when the study of emotions is under scrutiny. The "moral demands" made on respondent and questioner by the Socratic method would (in theory) place co-researchers in a position of vulnerability.

Seeskin is confident, however, that provided the process is adequately explained, and that refutation is seen as constructive it will in fact only "enable the respondent to say what he was going to say all along". His analogy that it is only "destructive in order to be therapeutic - like the doctor who must cut and burn in order to heal", is a vivid and highly appropriate one, given the context of the present study and the occupation of participants (Seeskin, 1987:5) Even so, the researcher felt a responsibility to be vigilant about the possibility of causing offence or emotional damage to individuals through the collaborative 'questioning' process.

The sensitive use of questioning 'probes' to delve further into individual responses was the technique used to clarify and expand on stated positions, and these ranged from detail-oriented probes to those used for elaboration and further clarification (Maykut & Morehouse, 1994:95). It has to be admitted that whilst the Socratic method proved to be enjoyable and highly effective as a means of inquiry, it did raise important strategic and ethical problems to which, of course, there were no easily accessible solutions. Details of the issues raised and their subsequent management are discussed in more colourful form in Chapter 6, when the words of participants illustrate somewhat graphically the situations which emerged. The overall gain for participants perhaps came in the increased sense of collegiality and recognition of co-dependence between colleagues; a refreshing change for some who had previously felt the presence of negative competitiveness between colleagues. It is with regard to this that the primary researcher/Unit Preceptors feel they had most influence on practice, as for once nurses of roughly equivalent grade and experience across a broad range of specialisms were coming together to discuss experiences in a mutually supportive atmosphere. Clarification of what constituted a particular support concept was also warmly welcomed by co-researchers as a major by-product of the study.

Data management in the workplace

Data collection and processing constituted a substantial part of the workload in the study and responsibilities for different aspects of management fell to co-researchers at various stages in the action research cycle. The planning and evaluation phases also necessarily involved a good deal of work. Apart from the collection methods already referred to, the principle method of information management centred on field notes, using a system suggested by McKernan (1991:94) *Observational field notes* represented a happening or event, including the exchange of views and/or outcome or discussion relating to a decision. *Conceptual field notes* were an attempt to relate theory to practice and vice versa, and allowed co-researchers to make connections between theoretical positions and the lived experience as communicated through and between groups.

Procedural field notes were used to send messages or queries relating to procedural or organisational matters. For example, one unit preceptor arranged for a box to be held in nursing management so that she could access them easily, whilst another preferred to communicate with co-researchers by using a strategically placed notice board. Even the tiniest scrap of paper could convey important information about the implementation of the study, so that all materials used (including participants academic essays or literature searches) contributed to the overall mass of data collated. The primary researcher's *interview notes* and *analytic memos* were however stored separately, and whilst access to notes could be obtained for verification of accuracy by individuals, this was effectively controlled by the unit preceptors, in order to maintain communication links whilst retaining confidentiality. The researcher's own diaries therefore constituted the only instantly available synthesis of material acquired from all sources.

Coding of categories in the data

Facilitating a critical examination and synthesis of the data clearly could not be done without some form of coding of the emerging data. At the most basic level, so that the primary researcher could distinguish between material coming from different sites, this was done with coloured highlighter pens, with each piece of paper or document being marked in the top righthand corner with one of five colours. The primary researcher could then enter any relevant material directly into her own diaries (in summary form) before storing it as appropriate. This also meant that papers could be dated and filed for future consultation.

In the first few weeks of data collection it soon became clear that some structuring of the material would be necessary to facilitate cross-referral, and to begin to get some measure of the theoretical concepts which would inform any future theory generation.

Several options were experimented with. The most useful and ultimately most theoretically stringent was that of coding according *not* to the type of data or specific method used to acquire that data, but to aspects of the study itself. Thus data was divided into three conceptual blocks, namely those relating to:

- (1) INTERPERSONAL ASPECTS OF LEARNING, i.e. those aspects apparently shared by all participants in the study;
- (2) PERSONAL ASPECTS, i.e. those relating to individual experiences;
- (3) CULTURAL ASPECTS, i.e. those aspects which seemed to represent the particular occupational and cultural milieu in which the study was conducted.

In this way it was hoped that the necessary separation between culturally specific aspects of learning support could be distinguished from those that might apply to any person or group experiencing a similar work transition. However, in order to allow detailed examination of the data to take place in this way, it was necessary to further sub-divide categories into the user codes described below. These codes then became the central organising principle for assimilating and analysing the various forms of data available. They also allowed co-researchers to structure the data without having to worry about the particular source of that data, although this was usually self-evident in the form in which it was stored.

Fig 2. Coding Mechanisms Employed

(1) INTERPERSONAL

SIG/ = data referring or relating to perceived 'significant others' in the role learning process

ROM/ = data referring to role models identified or discussed in the study

CONFL/ = data referring or relating to value conflicts perceived between individuals (usually between preceptor pairs, or between a partner and a colleague)

(2) PERSONAL

ACH/ = data concerning achievement related beliefs and perceptions of self-worth

FEE/ = data relating to feelings and emotions expressed by participants

BEL/= data relating to changes or modifications in personal beliefs about new role learning brought about by personal involvement in the present study

(3) CULTURAL

CONT/ = data relating to issues of control and power at work

VAL/ = data relating to value conflict and clarification between participants and their colleagues at work, and between participants as co-researchers

SURV/ = data relating to 'survival' strategies employed by participants to resolve apparent conflicts and 'manage' feelings at work.

By the strict (but far from infallible!) use of these codes it was possible to derive an overall framework through which to study and analyse the data from the perspective of social constructionism. It was also then possible to set constructs appearing in the data against those obtained via the literature review. The use of colour coding to identify different fieldwork sites meant that it was possible to conduct some comparative analysis of the data, although the need to maintain confidentiality for each site meant involving the primary researcher each time co-researchers wished to cross-refer.

As might be expected, power and control issues were common to all sites, although the expression of value conflicts and emergent coping strategies were markedly different for each area.

Analysis and assimilation of Literature

The contribution of the literature review to the ideas and strategies devised through action research in this study was substantial, although other accounts of action research consulted pay little, if any, attention to the review as a collaborative or interactive process.

The primary researcher held the view that in order to engage co-researchers' interest and enthusiasm in the study it was important not simply to impose the primary researcher's distillation of her own reading and opinions. Rather, by proposing that all co-researchers could share in and develop a database on issues related to learning support it was hoped that a diverse range of interests and views would be represented. This would also help to develop co-researchers' confidence in bringing scholarship and research to bear on practice as a matter of course. As Lathlean has warned, "true" collaboration in action research raises all kinds of ethical questions, not least to do with the 'ownership' of the research design and the interventions which follow (Lathlean, 1996:36).

As Goulbourne has argued:

"Critical reflection is a skill that precedes readiness for self-directed learning....Critically reflective practitioners can articulate clear and informed rationales as to why they do what they do, justify their decisions and make sound clinical judgements".

(Goulbourne, 1997:149)

Collaborative involvement in the literature review process therefore helped to motivate co-researchers as learners and critically reflective practitioners by improving their feelings of self-efficacy and respect; by helping them to realize they were able to reflect on and learn from experience, and by enhancing their self-image through positive interaction with the group (see Jarvis & Gibson, 1997:74). A synthesised literature review based on the primary researcher's distillation of literature read and discussed as part of the continuous action research cycle is presented in the next chapter. This is, of course, a selective review, and is necessarily only one interpretation of the vast amount of material processed.

A SELECTIVE LITERATURE REVIEW

Learning Support from the Perspective of Human Ecology

Introduction

Bringing together a range of disparate and sometimes conflicting views on matters relating to learning support is far from easy. It is important to stress here that the literature consulted by the researcher on preceptorship which was examined as part of the her taught MEd degree could not be subsumed into the present research submission because of university regulations, even though it was clearly utilised and referred to by co-researchers throughout the study. As a distinct entity, then, this review seeks to synthesise other literature which has impacted on the evaluation of preceptorship in practice.

The earlier review may therefore be referred to separately, while more recent material on preceptorship is analysed along with other work in different chapters throughout this thesis, as the points and issues raised are reflected on as part of the action research process. In order to provide some structure to the review presented here, the primary researcher decided to 'interpret' the new literature surveyed from the perspective of 'human ecology', largely because this mirrored her own philosophy about the nature and purpose of education, and the possibilities inherent in education for making change (and perhaps progress) a reality. It is therefore acknowledged from the outset that this represents only one interpretation or 'construction' of the material presented, and thus is subject to the selectivity and subjectivity of the researcher herself. Constructs and discourses which were of particular interest and relevance to the study included emotions and 'emotional literacy', socialization processes, ideas about job strain and possibilities for acquiring control over the demands made on individuals as they adapt to new work situations.

The Perspective of Human Ecology

Ecological ideas in social and political thought are said to constitute an "intrinsically critical science with subversive and revolutionary potentialities such as to overturn world views and inspire new values" (Hayward, 1995:8). Hayward stresses the distinction to be made between narrow conceptions of ecology as a professional science, and ecology as a political or philosophical movement, the latter of which (in his view) is the result of growing human concern over environmental crises. As such it is a reaction to the current legacy of 18th century Enlightenment science:

"In each area of Enlightenment a dark underside could also be identified: for example, growth in wealth and cultural refinement for some only meant intensified exploitation, misery and even slavery for many others; advances in scientific rationality could also mean spiritual impoverishment; development of technology could be used for destructive as well as productive purposes, for coercive as well as liberatory ends; the rationalization of social relations could spell the breaking of traditional bonds of community, with human rights being honoured more in form than in substance" (Hayward, 1995:12)

The sociologist, Ulrich Beck, in his conception of the 'risk society', has argued that the real critique of science and technology lies in the failure of techno-scientific rationality to face growing risks to civilization. He believes that:

"the sciences are *entirely incapable* of reacting adequately to civilizational risks since they are prominently involved in the origin and growth of those very risks. Instead - sometimes with increasing pangs of guilt - the sciences become the *legitimizing patrons* of a global industrial pollution and contamination of air, water, foodstuffs, etc., as well as the related generalized sickness and death of plants, animals and people" (Beck, 1992, tr. Ritter. (author's italics) : 58)

Denials and resistance to danger come in many guises, the destruction of nature being characterized by what Beck calls "a loss of social thinking" in society; or what Sloan has described as modernity's "damaged life". It would appear that the human psyche is having a hard time trying to come to terms with the post-modern reality of everyday living. For example, when Sloan asked students studying social change to describe the main problems of modern life, they commented on "the pace of change", the "decline of certainty and belief", "unfulfilled expectations", the "decay of morality" and "meaninglessness" (Sloan, 1996:9). Sloan attributes this crisis to what he portrays as the inadequacy of modern individuals, who seem "to have few symbolic resources with which to comprehend the apparent chaos of modern social and personal life". He writes of the "destabilizing, dizzying effects of relativistic education in which all beliefs appear to have equal value", so that:

"[H]anded down beliefs are subject to a kind of deflation to the status of mere attitudes. As their limits are discovered in the practice of everyday life, they lose their motivating power. Ideas crumble, faith withers, hope fades. One step beyond their lies perhaps the most intriguing aspect of the modern problematic: the collapse of meaning" (Sloan, 1996:11)

The concept of *human ecology*, seen from this perspective, could be described therefore as *an attempt to elicit and restore meaning to social life*, and to preserve, in the interests of social justice, a value system which will help to focus energies on adapting to ever changing social conditions. In relation to the researcher's thesis, this is an important prerequisite for the *emotional* survival of a group of people attempting to deal with those environmental and social problems which impinge on their sense of community and belonging, their perceived value in human society, and the extent to which their integration is enhanced, or mitigated against by their collective (as well as personalised) educational and social experience.

Bringing the abstract back to the concrete, then, it is to place the nurses involved in the present study within a social and cultural context which recognises and reflects the wider concerns of their human experience, some of which may be explained by the insights provided by a human ecological interpretation of the relevant literature.

Adult Education and the 'Risk Society'

Theories of reality ignore the sciences at their peril (Ferre, 1996:307). Ecological disturbances not only threaten our quality of life - indeed, our very existence - but "new technologies for the organization of labour and communication between people (computerization, mass media) reform the organization of social life in a way that was neither foreseen nor planned by any political decision or controlling agency" (Jansen & van der Veen, 1996:123).

Beck's concept of 'risk' as alluded to above, however, is said to have challenged many traditional sociological assumptions about the stability and regulation of modern society, and any possibilities for the regularization and standardization of social life. Instead, his conception gives particular prominence to the place of individual autonomy in a context of growing uncertainty, hazard and deregulation (Turner, 1995). For adult education, this "state of affairs" means that issues of social inequality and the marginalization of social groups remains an important but not necessarily central focus. For Jansen and van der Veen, the dominant ideology of the 1970s which saw the fruition of the welfare state, also saw adult education as emancipatory, aiming at the empowerment of people from the conditions which limited them.

As such, progressive adult education "became more and more reduced to work with deprived groups, developing methods that became closer to social work" (Jansen & van der Veen, 1996:125). These authors accept Beck's thesis that 'reflexive modernization' (see Beck, 1994) produces risks which affect more than the life chances of "socio-economic deprived groups". Their concern is rather that our lack of control over techno-scientific innovations masks deeply hidden socio-cultural contradictions which cannot be resolved within existing frameworks. They point to what they describe as the "pitfalls of individualization processes" which have more recently put materialism and the individual at the heart of economic life:

"[T]he diminishing influence of traditional philosophies of life and ideologies makes people look for identity in much looser *lifestyles*, which express themselves in a person's preferences for leisure activities, home furnishings, dressing and opinions about work and career, type of social network, linguistic usage etc....Lifestyles are often no more than patterns of conspicuous consumption, sensitive to fashions and trends exploited by commercial interests."

(Jansen & van der Veen: 1996:127)

They argue that adult education therefore needs to move beyond instrumentalism towards helping people to take greater personal responsibility for their actions and attitudes, as they adapt to "uncertainty and fear of failing". Adult education will have to become more involved in enabling individuals to devise their own decision-making and problem-solving networks. This may help to bring about new forms of community which, in turn, may allow them to overcome "the obstacles to self-responsibility" erected by prevailing political and economic structures, and at the same time "stimulate reflection in a Socratic way, i.e. [by] raising awareness of the crucial questions to ask instead of pretending to know the answers". (ibid:128-129,134).

This would be seen by Ferre as a profoundly ecological view of adult education, in that it would hope to deal with the complexities of modern living; recognising Odum's seminal definition of ecology as "the study of the structure and function of nature, it being understood that [hu]mankind is part of nature" (Odum, 1971:3, quoted in Ferre, 1996:310).

As far as Ferre is concerned, then, the key to ecology lies in *the study of relationships*: in being both holistic and environmental in outlook, in so far as the "web of connections must go far beyond the human situation and fully involve the natural order" of things and persons (Ferre, 1996:306).

Ecology and environmental psychology

Ecological theories appear to have dominated the field of environmental psychology. The relationship between humans and the world they inhabit is a core feature of the psychology of perception, and in particular James J. Gibson's theory of 'ecological perception' (Gibson, 1950), and the field theory and 'psychological ecology' emphasised by Kurt Lewin (Lewin, 1951). Lewin appears to have supported the phenomenological study of human behaviour, in particular, offering new insights into the 'channelling' of human instincts and actions and the apparent function of 'gatekeepers' in controlling access to alternative routes or sources which may guide human progress (see Bonnes & Secchiaroli, 1995:42/43). In addition to *attribution theories* which may help us to explain or understand others' behaviour towards us, there is also the psychological concept of *intentionality*, (Heider, 1958), which is based on the premise that in order to predict and control our world we must look for *causes* in the events that surround us (Hinton, 1993:139).

These causes may be viewed as internal, and thus generated by the person, or external, and caused by the situation, (Fiske & Taylor, 1991:48). Such assessments may then be mediated by what is described as a rationalisation of thoughts and emotions regarding a particular situation - and any perception of personal or communal threat - together with an appraisal of any social support networks available. In contemporary emotion theory, for example, appraisal is thought to be the central explanatory concept (Parkinson & Colman, 1994:10).

It would seem, therefore, that in examining the 'lifeworld' of co-researchers in the present study, some consideration had to be made as to the personal/interpersonal and social constructions of their work-related environment/s, and to the (perceived and espoused) causes and intentionality of prevailing practices and values at play in the context of beginning nursing practice, as well as in the possible structural and cultural policies relating to their management and employment within a mainstream public sector occupation.

One extremely productive and helpful way of illuminating the issues is to explore environmental and human concerns through the metaphor of *safe space*, a concept first encountered by the present researcher when working with the clinical psychologist and psychiatrist Anthony Fry. His book, entitled "*Safe Space- how to Survive in a Threatening World*" (Fry, 1987), is an accessible and holistically derived treatise on the ways in which human beings can find affirmation and support through human relationships, and in seeking an appropriate balance between the personal, social and (perhaps) *anti*-social challenges affecting everyday experience.

The Psychology of 'Safe Space'

Fry articulates safe space as the environmental conditions humans need in order to sustain themselves. Although cultures may change, the one (so far!) constant element is the continuity of being human. "In amongst the artefacts of culture, technology and social organisation, we remain soft and naked - born from the womb, eating, sleeping, loving, reproducing, building, creating and growing old". Inherent in all of this, however, is the paradox that "the very technology we have developed to provide those needs - energy, food, social structure - is all too often failing to fulfil its promise". Natural cycles begin to fail, families and communities lose their stability: "A common theme emerges - the world is becoming unsuitable for human consumption - the world is becoming unsafe" (Fry 1987:1). Safety is, however, a relative concept, dependent on our perceptions and responses to threat. The Oxford English dictionary defines the noun *safety* as "the condition of being safe; freedom from danger or risks" (SOED,1991:1061). It is hard to envisage a situation of absolute safety, however, as to be so would be at odds with popular conceptions of reality. The adjective *safe* is more helpful, in that this is described as "affording security", being "reliable; certain; [something or someone] that can be reckoned on" (ibid:1601).

Safe space and the 'empirical self'

The idea of personal 'space' can relate to our bodies, our immediate spatial environment, the place where we live, at a concrete level; or, on a more abstract level, as that 'mental space' which is said to exist outside of our physical selves, but within our consciousness; what the pioneering psychologist William James described as the "me" or the "*empirical self*".

It is interesting to note that Personality, as a movement within early psychology, grew from the notion of a hierarchy of 'selves', (the material self, the social self, the spiritual self) which together constituted the person and her or his personality (Lundin, 1991:101/2). This separation of mental from physical space seems to be important when trying to create the right conditions for psychological 'safe space', and it is necessary to acknowledge, therefore, that the body is gendered to the extent that men are said to view "the relationship of man to body as one of master to servant. Like a bad employee, or a recalcitrant family member" who has violated expectations of its conduct.

"As a general surmise, the essence of a man's personhood is merely housed in his body. This body is an asset when it works well, and it is a liability when it fails the person"...

(Gergen, 1994:36)

In contrast, through the study of autobiographies and personal narratives, Gergen found that women refer to their bodies as integral aspects of their identities; "they refer to their bodies, characteristics and processes, using "I", "me", "my" and "mine", rather than "it" as men do" (Gergen,1994:36). Our bodies are the natural environments within which we, as moral agents, operate; but it may also be the case that our moral condition/s depend on our management of the body as a personal responsibility (Turner,1995:86), hence the idea that disease "threatens the moral management of our bodies by robbing us of voluntary control and organization" (ibid:87).

Psychological threats to our perceived 'safe space'

This attitude towards coping with perceived threat and the apparent human need to retain personal control is exemplified in the following extract from a general practitioner's account of his early years as a medical student, and his transition to qualified doctor status:

"For the young medical student who is well into the energy-consuming processes of the personal development necessary for his age, and whose life is devoid of adequate supports or of the strength derived from experience, there flows a succession of other people's distressing feelings and the raw emotions of his chosen career. These seem to pack themselves into his day, one on top of another, too fast to contemplate, and so many, so fast, demand he distance himself behind the white coat of one who seems to understand illness, and who may be presumed to prevent death. He is pressured to join a club of people whose membership enables him to enter the hospital wards not as a patient - a person who can be ill, disabled or in pain - but quite, quite separate, as 'doctor'. He puts on a cloak of defence against human emotions, which too frequently also separates him from his own tender growth and sensitivity..."
(Holland, 1995:14)

Emotions and Work

Emotions, it would seem, are not welcome in the *rational* organization. Employees may exhibit emotions infrequently (and then only if they *must*), whilst managers are expected to remain immune to them, steadfastly retaining their presumed natural objectivity and logic in the face of any *irrational* emotional forces. This "gendering of emotions" perpetuates a tradition which couples emotion with women in direct opposition to reason and men; "the consequence of this is that the former is denigrated in contrast with the latter, as is prevalent in male-stream [sic] scientific discourse" (Swan, 1994:91).

Emotions have the reputation of being chaotic, subjective and weak in the face of the bureaucratic preference for a rational base. Emotion is therefore marginalized in organizations, in the widely held belief that "rationality and the control of organizations are not only inseparable but also necessary for effective organizational life" (Putnam & Mumby, 1993:41).

The dominant assumption in Western psychology has been that emotions are simple disturbances of the efficient functioning of goal directed behaviour, the implication being that emotion therefore interferes with our effective functioning, *getting in the way of* otherwise rational and decisive actions. This view is now being challenged, however, so that emotions may be understood "not to distort [our] rationality, but rather, the opposite: in the perturbations of the smooth surface of habit, of plans, of schemes that do not always go as we might have planned, we can sometimes catch a glimpse of something real in us that may point beyond the issue of our achieving our next goal" (Oatley, 1992:410).

At the level of organisation there is yet another dimension - that of the '*psychic prison*', an idea first explored in Plato's *Republic*, but related to modernity by the management writer Gareth Morgan. Morgan suggests that like the people within the underground cave cited in Socrates' allegory, people may become imprisoned or confined by the images, ideas, thoughts and actions to which conscious and unconscious social processes give rise. People can become "trapped by favored [sic] ways of thinking", and by "constructions of reality which at best give an imperfect grasp on the world". While organizations may therefore be viewed as socially constructed realities, "these constructions are often attributed an existence and power of their own that allows them to exercise a measure of control over their creators" (Morgan, 1986:199).

Morgan uses this to explain why some people resist change, arguing that they are often the victims of their own misapprehensions. He examines organisations from the psychoanalytic perspective of repression and the feminist perspective of patriarchy, seeming to intimate that we are all at risk of falling prey to the blinding irrationalities of human feeling by failing to control our human impulses.

In his view, "hidden forces" which lead us to over-depend on hierarchies and organizational rules can get in the way of being creative, organic and innovative. The bureaucratic emphasis on maintaining control (e.g. in standardization procedures, benchmarking, scientific management) is therefore part of the human drive to maintain social and collective order in our lives, thus making it amenable to our control:

"And in doing so, we create the myth that we are actually in control, and that we are more powerful than we really are. Much of the knowledge through which we organize our world can thus be seen as protecting us from the idea that, ultimately, we probably understand and control very little. Arrogance often hides weakness, and the idea that human beings, so small, puny and transient, can organize and boast mastery of nature, is, in many respects, a sign of [our] own vulnerability"

(Morgan, 1986:214).

Thus our metaphorical drawbridges and lines of defence are drawn, so that perceived threat may be met with the time-honoured response: a negation of our human frailty and the paradoxical expression of our human strength. This entails on the one hand the expectation that we should be able and ready to confront and deal with our human problems, while on the other, we have only meagre resources on which to draw in times of need or trouble. For the person in isolation, who has little social support or previous positive experience on which to rely, the psychic prison of their emotions can begin to close in. Emotions become central to their existence. It is interesting to note that this idea of *employee resistance* remains a persistent, significant and remarkable feature of contemporary organizations, and that throughout the 20th century it has been the primary analytical concern of scholars of organizations as well as a pervasive feature of labour process practices (Collinson, 1994:25/26).

The Study of Emotions

Swan remarks that the word 'emotion', first came into use in the 17th century in place of the idea of 'passion' as subordinate to reason. In the period known as the Enlightenment:

"the valorization of reason and mind over emotion and the body rigidified. Reason became the privileged knowledge for 'mastering' the world, and particularly science, the means of dominating nature and its resources for men's designs. Together reason and science would facilitate what an influential male minority defined as social progress" (Swan, 1994:92)

Distinctions between emotions and beliefs are thus open to contention and influenced by stereotypes, for example, in the idea "that emotions are unlearned or innate, whereas beliefs are learned in society. Emotions are impervious to teaching and argument, beliefs can be modified by teaching. Emotions are present in animals and infants as well; belief and reasoning belongs to mature human beings alone" (Nussbaum, 1994:79).

Elsewhere in the literature it is evident that - particularly with regard to research - emotion has traditionally been perceived as essentially a female characteristic generally considered to be an undesirable, or 'contaminating' phenomenon unworthy of serious scientific attention (e.g. Kimble, 1961, Fraisse & Piaget, 1968, Spielberger & Sarason, 1975). In the main, emotion studies have tended to focus on the impact of emotions on the physiological systems and/or neural networks of the human brain and those of other primates, (e.g. see Plutchik, 1994, Ortony et al, 1988, Brewin, 1988, Jauregui, 1995); on the instinctive origins of emotional behaviour (Ízard, 1923) and, more recently on the social psychology and sociology of emotional responses and adaptation to changing social structures and conditions (e.g. Kemper, 1990, Lazarus, 1991, Parkinson, 1995).

Psychologists Harre and Gillett have, however, tried to establish a 'discursive' breakaway movement from conventional psychology's mechanistic/cognitivist view of emotion, towards a broader conception concerning the "discursive origins of the self, the problem of agency, and a thoroughly social understanding of personality" (Harre & Gillett, 1994, back cover). Ortony et al have made the point, however, that modern theories of cognition have not made clear its associations with emotion, perhaps because of the emphasis psychology has tended to place on "human information processing". They argue that this approach has failed to make progress on "problems of affect"[i.e.mood], so that, given the "abundance of psychological evidence that cognitions can influence or be influenced by emotions, the absence of a viable account of the emotions compatible with a general theory of cognition renders existing theories of both inadequate" (Ortony et al,1988:5).

Individual differences in dealing with particular emotions also seems to have confounded psychologists in the past, although Lazarus is optimistic that the current trend is to recognize that these "sources of variation" help rather than hinder theoretical development, giving rise to the growing popularity of transactional, process and system formulations of emotion work. Lazarus concludes that social communication is an "important adaptational function of emotion" (Lazarus,1991:21).

The ability to deal with strong emotions is sometimes connected to ideas regarding intelligence. Andersen has noted, for example, that theories of intelligence have been used to justify social-economic inequalities, so that those "at the 'bottom' of society have been said to lack something....The poor have always been blamed for being poor by those who have wealth and power. One particular inferiority of poor people is said to be their innately inferior intelligence" (Andersen, 1978 in Andersen,1994: 121).

The relevance of this to the present study lies in the relatively low status afforded to nurses in 'professional' society, so that in spite of their many professional attributes they are increasingly "transformed by managerial authority" [through the summary redistribution of resources and power], into "technical workers with fewer of the trappings of professionalism" (Friedson, 1994:117). The nurses' political response to this managerial dominance has typically been viewed as emotional and a product of *tribalism* (see Beattie, 1995:11), so that nurses have to adjust to their "humble place in the health hierarchy....An important part of their occupational socialisation is the constant enactment of ceremonies of power to reinforce existing inequalities" (Perry,1993:50). The inference here is that, despite their vast numbers, nurses are generally too emotional to view their situations rationally due (at least in part) to their perceived lower intelligence and status in the ranks of health workers.

Concepts of intelligence

Influential concepts of human intelligence which have dominated psychological thinking in the Western world are largely quantitatively derived, being based on psychometric scales artificially constructed and "hardened in the crucible of statistics" (Andersen, 1994:119). This combination of Western individualism and the 'hard science' of psychology has more recently spawned theories which have their foundation in psychometric and personality trait assessments, the best and most relevant example of which is probably Goleman's construction of '*emotional intelligence*' (Goleman,1996).

The limitations of traditional psychological thinking are more readily being addressed in the discipline through the development of critical approaches, a process of self-reflection which has been described as 'metapsychology'.

Disillusionment with the "great man" [sic] approach to history may be partly to blame, so that the time seems right to question established thought and practice: in a sense to "put Psychology in its place" (Richards, 1996: 1/6). Biases and previously accepted pedagogical practices are beginning to be constructively questioned by self-confessed 'maverick souls' within the discipline (e.g. Cherry, 1995), and by confronting the agenda created by psychology for the regulation and control of individual and family life (Burman, 1994: 188). It is vital, therefore, not to depend wholly on psychology for insights into emotional processes, but rather to approach the literature from a more lateral perspective, taking into account the varying perspectives and 'agendas' of other knowledge domains and fields of practice.

Fear of Emotions

Psychotherapist and writer, Susie Orbach, is unequivocal about the problems people experience in expressing and coming to terms with their emotions in everyday life. She believes that we need to challenge our culturally transmitted fear of emotions, as this only exploits and distorts peoples' longings and desires:

"A fear of emotions curtails our health, our marriages, our relationships with children as well as our capacity for citizenship. Until we challenge the consensus that keeps us emotionally illiterate, our desire for recognition, for intimacy, for selfhood and for community will continue to appear in fragmented, distorted forms"
(Orbach, 1994: 6)

This phenomenon of emotional illiteracy is not new in the literature. John Macmurray, the Scottish communitarian philosopher whose work is currently enjoying a renaissance in contemporary political circles, had very definite views on the subject in 1935.

He lamented the human failure "to educate the emotional life". He argued (somewhat emotionally!) that the exclusive concentration on training for the intellect, and the subsequent relegation of the emotional life to a subordinate status could only make pupils "capable of determining the means to human life and very little of living it". He echoed earlier discussions concerning the instrumentality of education. The intellect, in his opinion, "arises directly from the emotional life". When the intellect (alone) takes charge, (and this could perhaps be understood in the modern vernacular of the 'head ruling the heart'), the inevitable result is specialization and the substitution of the part for the whole. Emotion is therefore *the* unifying factor in life:

"[A]ny education which is fully conscious of its function must refuse to treat human life as a means to an end. It must insist that its sole duty is to develop the inherent capacity for a full human life. *All true education is education in living.*
[researcher's italics] (Macmurray, 1935:42-3)

The Quest for Emotional Literacy

It could be argued that this 'quest for emotional literacy' has been popularized in the literature (and in the media generally) in recent years by what has become the established 'stress' discourse. The concept of stress is certainly no stranger to health care staff, and to nurses and doctors particularly, (e.g. Holland, 1995, Sutherland & Cooper, 1990); so much so that the existence of stress among nurses is generally taken for granted by writers (Marshall, 1980 referred to in Sutherland & Cooper, 1990:185). Nursing is therefore "generally acknowledged to be a stressful occupation in a stress-filled society" (Jacobson & McGrath, 1983:xi), and there is little outward evidence to suggest that other health professionals might fare any differently.

Problems of the Stress Discourse

The cost to the UK economy in terms of NHS treatment for stress related disorders has been estimated at £5 billion a year, with the additional burden of associated sickness benefits, early retirement or compensation payments and the cost of replacing staff falling heavily on employers and government alike (Meusz, 1995:1). The stress industry is manifested in the popular press and in the wealth of articles and self-help materials on offer for dealing with the phenomenon on a personal as well as organizational level. The popularity of the stress concept is said to be due largely to research on life events and illness, to the point that it has been described as the stress revolution (Smith, 1993). More worrying, however, is the claim that the stress discourse has allowed for "a relatively straightforward and easy mass production of books, articles and PhD's, [that] has gained legitimacy within and beyond academe on the basis of a seemingly objective and scientific method" (Newton et al, 1995:48).

Newton has warned that it is important to relate stress to other discourses, or there is a distinct danger of being seduced into believing that popular representations of stress constitute its reality. The difficulty with stress in that its power as a discourse lies in our not knowing if we have become more stressed than before, so that stress surveys may just be measuring the power (and therefore our engagement with) the stress discourse, rather than the real experience of stress. Stress itself may therefore be caught up in the debate about work roles and practices. For example, modern conceptualisations of stress may have been perceived differently in earlier times, being viewed as honest hard work (characteristic of the Protestant work ethic), or as a service to a higher authority, as in early Christian and medieval conceptions of work in exchange for rewards in the after-life (see Ransome, 1996: 99). Where once hard work held meaning, by contrast, stress in the late 20th century contributes towards *meaninglessness* (Sloan, 1996).

The real power lies in the language of stress, so that from a traditional Marxist perspective:

"[S]tress, with its emphasis on individualism, apoliticism, ahistoricism and so on can be seen as just one further reflection of a pervasive ideology which glosses over the inequalities of power reflected in existing social structures, and lays the blame primarily on the individual.....People believe in the language of stress...because they have swallowed capitalist ideology...." (ibid:11)

Although different models of stress have been articulated, there seems to be a general consensus that it serves a purpose. If it is perceived as manageable then it will actually be of positive benefit to the individual, so that at one end of a continuum there lies 'good stress', (known as "eustress"), while at the other end there is the more negative, unmanageable and potentially damaging personal state described by Selye as "distress" (Selye,1976).

It could be argued, however, that it is the more recent politicization of stress which pervades the popular and academic press (notably in teaching as well as nursing, see, for example Kyriacou,1989), so that occupational stress has been brought into the front-line of industrial relations. The modern expectation of all workers across the organizational hierarchy is the required ability to manage a fair share of the stress manufactured by the drive for corporate efficiency. Productivity, change in employment levels and profitability are among the measures currently used to assess effectiveness within the UK public sector (Flanagan & Spurgeon, 1996:40), although they could also be described as the means advocated by central government for acquiring and maintaining economic 'competitiveness' generally (Board of Trade,1996).

Jacobson has described the powerful "professional mystique" which has arisen in what she calls the caring professions, saying that in searching for meaning, novelty and fulfilment in their work nurses look for - but don't always attain - certain expectations of nursing work. Contrary to popular expectation credentials don't always indicate competence or a high degree of success in work; the so-called professional status of nursing does not necessarily lead to greater personal autonomy and control at work; clients aren't always co-operative and grateful, and last - and perhaps most crushing of all - [in the researchers' view] relationships among professional colleagues are not characteristically supportive or collegial. Jacobson blames this mismatch of expectation for the increasing tendency among nurses to feel extremes of job stress, added to which:

"The view that 'a nurse is a nurse is a nurse' has been all too common, as has been the expectation that nurses be selfless. In the popularity of 'burnout', nurses hope that their services will receive a long overdue recognition, and they feel justified in insisting that their needs as caregivers be met"
(Jacobson, 1983: 104).

Safeguarding Emotional Health in Organizations

Strategies for identifying and managing stress are a common feature of the emotions literature (e.g. Flannery, 1990), with the emphasis focusing less on structural causes and more closely on the affected individual taking personal responsibility for creating and maintaining an assertive and balanced lifestyle based on emotional and physical 'fitness for purpose'. On the evidence currently available, it would seem reasonable to assert that human stress has been problematized and commodified here in the UK (by adult educators as well as employers and medical advisers), so that the responsibility people feel for taking control of their lives may have in reality contributed to a convenient broad political strategy to maintain control over the population.

This is particularly obvious, for example, in the tactics employed by central government in the rhetoric of health promotion (e.g. DOH 1992 *'The Health of the Nation'* report, see also the conclusions of the *Research Unit in Health and Behavioural Change*, 1989:153).

Theories which ostensibly address the human difficulties experienced as the perceived consequence of stress rely heavily on the biological concept of adaptation, defined as "the action or process of adapting to or modifying so as to suit new conditions" (Shorter OED:22). Thus the qualitative emphasis is placed on the 'person-environment fit', with the onus being clearly on the person - rather than the environment - to alter and adapt to suit prevailing or anticipated conditions. If stress really is the product of social and behavioural science research as Pollock has claimed (Pollock, 1988, Newton, 1995), then this may be [yet] another example of the Weberian iron cage which forces us to rationalise and give a name to something which reflects our communal experience, but which results in a culture of negativity.

However seriously stress is taken as an organizational health issue (see Morton-Cooper & Bamford, 1996), it is nevertheless a truism that stress is an important construct when considering the emotional impact of modern living. For many of us the idea of stress may be a helpful way of describing the pressures and constraints inflicted (and sometimes perhaps, self-inflicted?) on us by contemporary ways of working and daily living.

Approaches to stress research

From a research point of view, two approaches to the study of stress have been reported by epidemiologists attempting to clarify any relationship between the stress experience and illness. One approach views stress as too vague and ill-defined a concept for valid scientific examination, while the other believes that standard psychosocial instruments can be administered, and results entered into multivariate analyses so that causal inferences may then be derived (Kasl & Cooper, 1987:4). These authors conclude that the major limitation of stress research to date has been its inability to get to grips with the qualitative detail. Thus the "need for mass information necessitates standardized, reproducible measures of both psychosocial factors and health. This limits the subtlety of detail that can be collected and hence the insight that is possible into the human processes involved in links between putative causal and outcome measures" (ibid:5). Over-reliance on questionnaires and interviews to assess job stress has also posed a perceived threat to the scientific validity of experimental studies because of problems associated with single method self-reporting. Problems of *reactivity* and *attitude crystallization* (i.e. new attitudes forming or being created by the interview act), have emerged in addition to a distortion of data caused by a lack of interviewee confidence in the promise of respondent anonymity (Bailey & Bhagat, 1987:216/7).

Where individual jobs and careers are at stake it seems that few interviewees are prepared to wager all for the cause of empirical research! This seems to imply that interviews which attempt to measure stress are an inexact science, so that when considering the structure and conduct of proposed group and individual interviews for the present study it was necessary to explore different methodological tools for helping co-researchers "to think about their worlds and consider, possibly for the first time, the way they construct their reality" (Easterby-Smith et al, 1991:71).

It was important to be aware of the stress discourse and its relevance to participants, but not to let it 'swamp' other equally important concepts or constructs which otherwise might shed light on the workplace learning environment. In particular, it was necessary to root discussions about nursing work in the literature of continuing education, or any possibility for making the links (and appropriate distinctions) between factors relating to adults as adults, rather than nurses, would continue to elude the researcher.

Adult Development and Adult Education

Work on adult development has tended to be driven by the psychological tradition, focusing on the individual's internal process of development so that "the most prevalent theories are those conceptualized as a patterned or ordered progression tied to chronological time" (Merriam & Caffarella, 1991: 97). Tennant argues that two broad psychological perspectives are offered within the "normative rhetoric of adult education", depending on whether it is the social environment or the person who is at the centre of the theory. In the latter case the internal make-up of the person becomes the subject [sic] of scrutiny, in terms of being seen as an independent "autonomous dynamic", and thus independent of the social environment.

In the former the individual is viewed as dependent and reliant on the social world, so that the person can only be "explained and understood as a product of social influences, at least in all important respects" (Tennant, 1988:3). In both cases Tennant argues that prevailing theories have led to "an over-regular and over-systematic view of adult learning and development, which is best understood as a dialectical process subject to the vagaries of historical and social variation" (ibid:6).

He is not alone in berating adult education's predilection for quantifying and categorising. Elsewhere, it has been roundly criticised for reducing its efforts to a "discipline of four diseases", namely *gogymania* (an attack on the andragogy morass? see Davenport, 1993:109); *mapomania* (a fondness for making conceptual leaps in the dark so that any consensus on what constitutes the field of adult education is lost, leading to an obsession with laying and re-laying its territorial 'map'); *defnimanian*, (a propensity for constant re-definition of the obvious?), and *lexicophilia*, (an attempt to mark the boundaries of an uncertain discipline through a muddled use of the terminology, e.g. in the debates over 'lifelong', 'recurrent' 'continuing' learning and so on) All of this, the authors conclude, is indicative of a new discipline in search of itself, so much so that it has been slow to produce knowledge and build theory.

Linkage with other disciplines is not a sin, they say, but attempting to subsume other disciplines in defence of our own certainly is:

"Even if one believes that we have overstated the seriousness or extent of these problems, the fact remains that the discipline continues to entertain new terminology, definitions, and claims about what constitutes the domain of adult education without being drawn any closer to a resolution of concerns continually being raised about these matters in the literature" (Plecas & Sork, 1986:49/59)

Although it was tempting for the researcher to be drawn into the existing literature on adult development in the early stages of the present study, this temptation was resisted, largely because it seemed more important to have a grasp of socialisation processes as they occurred in the workplace.

Theories relating to the different stages of human development people are thought to experience could be read in context later (e.g. Fiske & Chiriboga, 1990) when the data collection was complete; but what was needed in order to construct a provisional model of learning support to help employees understand and manage their perceived personal transitions, was a better understanding of the micro-politics of workplace learning. Issues which required immediate and detailed exploration concerned existing theories of *emotional socialisation* and any work which might help to explain the emotional demands placed on workers.

This included the identification of any rites, rituals and practices associated with entering a job for the first time, and any material which might illuminate the function/s of emotion as displayed in individual or group processes at work. This was important information to be had in advance of data collection, or the researcher would be at a loss to recognise the vital clues or cues which indicated the involvement of emotions in the socialisation process.

Theories of emotional socialisation

The value of '*feeling rules*' in the workplace has been put forward in an influential text by Arlie Hochschild, whose thesis concerns the '*emotional labour*' people carry out as a part of their work roles. In what Fineman calls "an eloquent account of the social construction of emotion" Hochschild is said to have noted the peculiarity of modern urban culture for putting people outside the cultural frame of *feeling rules*, thus distancing themselves from more private feelings (Fineman, 1995:128, see also Hochschild, 1979, 1983).

Nursing and 'Emotional Labour'.

From a nursing perspective Smith (1992) has explored the use of these 'feeling rules' within the nursing culture. In particular, her study offered an examination of :

"the viability of emotional labour as a concept, nurses' different emotional styles, the [nursing] students' training trajectories and how they learn to care, the role of the ward sister in setting the emotional tone, the legitimisation of emotional labour and the forms it takes between both nurses and nurses on the one hand and nurses and patients on the other ...[to] see the strategies nurses adopt both to keep in touch and to protect themselves from their feelings" (Smith,1992:19).

At the root of Hochschild's theory is the idea that in order to manage their emotions, and to retain a sense of personal control, people will comply with certain emotional codes, they will "privately *labour with*, or *do work on*, their feelings in order to create the socially desired emotional expression and impression" (Fineman,1995:128). As Fineman points out, such feelings can amount to 'stress', and to continuing attempts at emotional camouflage, a process which can lead to additional tensions. We appear to 'look on' and make more specific choices about what we reveal of our feelings to whom and when, so that in this sense, "emotional labour is part institutional and part interpretative".

Most importantly, Fineman warns that analytically it is necessary to distinguish between two classes or types of feeling rules, those that are "explicit: deliberate, managerially contrived ways of serving the organization's commercial or supposed strategic ends", and those that are "implicit to the organization's informal culture, the procedures which help people to get by in everyday social interaction: they help protect or save face" (ibid:128/9).

The cultural validity of feeling rules and their relevance to beginning practice is therefore potentially of great value in arriving at an explanation for different behaviours and value stances. Such emotional care, Smith concludes, is not easily costed, and may be in danger of being marginalised as health care moves further into the marketplace (Smith, 1992:137). It is necessary, therefore, to include it in any analysis of organisational policies in the workplace, with proper consideration being given to its manifestations at both a formal and an informal level. It also seems reasonable to assume that feeling rules operate at every level of the organisation, although higher levels of authority might imply more freedom to express feelings than the perceived lower echelons. Hence it also needs to be considered when assessing managerial responses to role change and role acquisition, so that organisational constraints are recognised for what they are, and not merely put down to managerial obstinacy! The researcher was already wise to the possibility of becoming "trapped between two major groups or factions" in the field (Easterby-Smith et al, 1991:63).

Emotion Work Skills

Goffman's (Goffman, 1959) work on the presentation of self in every-day life forms the basis of an attempt by researchers Raffaelli and Sutton to conceptualise emotion and its expression as part of the work role. They suggest that informal organizational feeling rules may actually be more powerful than formal socialization processes, building on Bandura's thesis that newcomers learn by observing and imitating more experienced 'co-workers', as in Bandura's rationalist notion of *self-efficacy*, so that those with "a strong sense of perceived self efficacy exert a greater effort to master challenging tasks than those who entertain serious self-doubts about their capabilities" (Hjelle & Ziegler, 1992:353, see also Bandura (1977).

This theory is representative of the social cognitive perspective in work on personality theory, and is an approach shared by Julian Rotter in his 'expectancy' theory of social learning (based on the formula *Behaviour potential = Expectancy + Reinforcement Value*). According to this theory performance therefore relates directly to whether the individual perceives an internal or external locus of control over their actions (Hjelle & Zeigler, 1992: 377/385, Rotter (1966).

Rafaeli and Sutton contend that the expression of emotions by members of an organization may "in the aggregate, have a positive or a negative influence on organizational performance", so that (by their definition) *emotion work* can bring about "immediate, encore and contagion gains (or losses) for the organization" (Rafaeli & Sutton, 1995: 119). These gains or losses may therefore be perceived as short-term, long-term or accruing, as in the case of the person whose performance leads to job promotion and greater recognition from the establishment. Despite the apparent simplicity of such a model for analysing the emotional 'infrastructure' within an organisation, these authors warn that the study of displayed feelings is "fraught with emotional hazards", a position which may have contributed to what they see as a dearth of literature on how emotions can be properly managed within organisations. They recommend the teaching of "*emotion work skills*", although they acknowledge the difficulties in trying to capture the complexities of emotional experience (ibid: 125).

One theory which has made bold attempts to confront these difficulties is that posed by Kramer in 1974, in her *postgraduate resocialization model* for the "resolution of value and role conflict between the generalized knowledge and skills acquired in the educational program [sic] and the specific behaviours required for successful accomplishment of stage one behaviours in the work setting" (Leddy & Pepper, 1992:69).

Kramer and Postgraduate 'Resocialization'

Kramer's model was originally devised as a response to the problems being experienced in the USA when nursing education moved from vocational to higher education (see Stuart-Siddall & Haberlin, 1983, Morrow, 1984) where it was identified as a valuable means for recognising the 'reality shock' of practice after the initial socialisation of college. As such it formed a useful method of *anticipatory socialization* which helped to frame the analysis carried out for the present researcher's work at master's level.

Kramer identified key stages in adapting to the reality of work, the first stage being described as *routine mastery*, i.e. the drive to function adequately within the anticipated work setting. The potential problem here (as far as Kramer was concerned) lay in the individual's preoccupation and "fixation" with acquiring technical skills above all else. Stage two she characterised as *social integration within the work group*, whereby the nurse receives recognition that she/he is functioning effectively. Stage three is expressed as *moral outrage*, when the new nurse realises and (perhaps) challenges the incongruities apparent in the work role and finds previous preparation inadequate for dealing with the difficulties this proposes.

The fourth and final stage, if it is ever reached, is that of *bi-culturalism or conflict resolution*, when individuals either "capitulate their behaviours or values" (i.e. which the researcher assumes to mean "fits in" with others' conceptions of how things should be), or they "integrate the professional and bureaucratic systems" i.e. 'become one of us' (Leddy & Pepper, 1992:69, see also Kramer, 1974:162)

Leddy & Pepper have highlighted the difficulty of analysing socialisation: is it a process, for example, or an outcome? The conflict may lie in our socializing nurses for what practice *should be*, rather than *what it is*, leading to conflict and the exacerbation of an already stress loaded role adaptation (ibid:73).

Corwin's Theory of Role Conception

Leddy and Pepper have also introduced the work of Corwin (1961) into Kramer's model, by suggesting that the moral outrage referred to earlier may relate to three separate role conceptions believed to be held by all nurses in varying degrees: those of the *bureaucratic*, *professional* or *service role conception*. It is the extent to which the nurse manages to deal with the emotions aroused by "biculturalism" and the attendant capitulation of values that makes integration possible thus explaining the level of resocialization obtained (see Leddy & Pepper, 1992:69, Kramer, 1974).

Entertainingly, Kramer has identified certain 'stereotypes' within this framework, described variously as '*organisation people*', '*rutters*', '*lateral academic arabesquers*' and '*bi-cultural troublemakers*'. When asked to assess their own positions in relation to this theory, co-researchers in the present study identified very strongly with these conceptions of themselves, recognising perceived emotional strengths and weaknesses within the stereotypes described. The proportion of individuals who recognised and acknowledged themselves as 'bi-cultural troublemakers' was very high across the population studied, which may indicate that in order to survive 'the system' some healthy antagonism between culture and personality has to be maintained.

As one co-researcher pointed out, however, it may also mean that "only the bolshy staff nurses succeeded in getting in" to the present study, a compliment to the researcher if not to the sampling process!

Theories related to 'Job Strain'

Job features which may affect job related well-being have been classified by Warr (1987,1994,1996) into nine main groups. These are:

- (1) opportunities for personal control and (2) for skill utilization
- (3) externally related goals (job/task demands, responsibility and role conflict)
- (4) variety of non-repetitive work
- (5) environmental clarity (which the researcher interprets as accurate job representation, clarity of expectations between employer and employee), but which Warr also describes as "low role ambiguity" and absence of job insecurity;
- (6) availability of money,
- (7) physical security
- (8) opportunity for interpersonal contact and quality of interaction with others
- (9) valued social position - seen by Warr as wider societal evaluations of rank and status, localized evaluation of importance within the organization, and "valued role incumbency" denoted by self respect in the job (Warr, 1996: 229).

Nursing as an occupation does not therefore evaluate positively against this particular "axis" of well-being. To begin with, opportunities for personal control (as will be argued in detail later) are few; opportunities for skill utilization are perceived as poor in relation to the increasingly specialised skills nurses have acquired, with increasing pressure being placed upon them to relate their performance to employer set local productivity targets (RCN,1994).

The perceived weakness of nurses as a professional pressure group (versus the "strengths of the state") has led to the reported "failure of nurses to achieve a reward system which recognizes the value of clinical nursing expertise": indeed the system of clinical grading (and therefore money available) is said to be having the opposite effect on pay and morale (Gavin, 1995:379). Demands on resources are well recognised as exceeding nurses' ability to supply, while variety of opportunity is negated by the paradoxical specialisation of expertise when the demand is for a 'flexible' workforce with minimal but transferable skills (McKenna, 1995). The concept of role in nursing has been challenged for its capacity to offer nurses the opportunity to develop "moral sensitivity" (Scott,1995:323) in the enactment of their roles and responsibilities to the vulnerable public, while the media has expressed moral sympathy with the nurses themselves for their debasement in a society which "pays more for serving hamburgers than for saving lives" (Christie,1995:11)

Subjected variously to 'activity analysis' and individual performance review, nurses can be seen to be having very little opportunity to develop "environmental clarity" in a work context which has achieved international renown for achieving the impossible against improbable odds. It has been suggested that while the blame for misuse of moneys and resources is often laid at the door of erring health workers and managers, it is in fact the "proliferation and misuse of technology" which is responsible for spiralling health care costs (Loewy,1995: 150).

As the Audit Commission has noted, in the absence of reliable "outcome measures" for nursing, discussions regarding the quality of nursing services has tended to concentrate on the process of care and organisational audit (Audit Commission, 1991:4), both of which place nurses in direct collision with the oncoming train of government criticism over the appropriate use of limited resources.

This development does not bode well for nurses' "valued social position", or indeed for their physical security: as security of job tenure is reduced by increasing use of short-term employment contracts and made all the more tenuous by the inconsistent application of performance review procedures. In terms of well-being then, Warr's Vitamin Model of mental health based on affective well-being, competence, autonomy, aspiration and integrated functioning (see Newell, 1995:91) places nurses in a composite (and somewhat contradictory?) state of arousal and depression, as distinct from the 'well' worker who enjoys a more energised and cheerful place in the world (Warr, 1996:225).

This unhappy situation may therefore be in violation of the "*psychological contract*" between employer and employee as referred to in the previous chapter. While the economic contract may be seen as concerning 'housekeeping' then, the psychological contract refers to issues of the 'spirit'. For the economist and scholar Fukuyama, then, the culture of nursing in British health care would be viewed as a "low trust" rather than "high trust" society capable of "sustaining sociability" (Fukuyama, 1995:149)

The Issue of 'Control'

Stress as a perceived imbalance between demand (or environmental pressure) and capacity to respond is a well known conception of the term and relates closely to ideas about 'loss of control' (Fisher, 1994). Fisher has examined stress in relation to the work of academics, and has defined control in this context as "jurisdiction or discretion in daily events and situations". She believes that perceived control is important with regard to threatening situations at work, because of the "power it gives to attenuate or reverse unpleasant events"(ibid:29). Thus the pleasure derived from controlling the environment and from command over situations can be understood as what Fisher calls the *discrepancy reduction model* (Fisher, 1994). Thus:

"the individual always acts to reduce the discrepancy between reality 'the way the world is' and his or her needs requirements 'the way the world should be'. Successfully reducing discrepancies created by daily life can be pleasurable in its own right and can reduce stress".
(Fisher, 1994: 30)

While this model has clear parallels with that offered by Kramer and resocialization, it shares the same dynamic flaw in that it places responsibility for controlling the environment squarely with the individual, a position which is deterministic in outlook, and a view which appears to the researcher to be somewhat naive and simplistic, offering much to the individual in theory but very little in practice. In terms of the support and challenge needed for making successful personal "role transitions" (see Fisher et al, 1990, Adams et al, 1976, Bridges, 1996, Daloz, 1986:213), its weakness lies in its adherence to the deficit model of 'managerialist' psychology, so that it is the worker alone who is seen as the maker and breaker of fortunes in the workplace.

This could also be described as an example of what John Field has elsewhere described as the 'pedagogy of labour' (Field, 1991), as part of the decisive reallocation of power over education and training heralded by the competency movement and technicist reform of workplace education (Alexander & Martin, 1995:83).

Thus Fisher's "mental assembly line" in (post) modern academia is in fact part of a wider governmental agenda to exert power over the autonomy and independence of universities and other (formerly?) powerful institutions. Returning to the problems discussed earlier in relation to the stress discourse, it is clear, therefore, that the language associated with emotion work should treat the stress concept with caution, lest it be drawn unwittingly into victim-blaming without due regard being given for the vagaries of variously unworkable systems (Fisher, 1994).

Scott counsels the use of practice based theory to ensure that even the widely held theoretical assumptions are always adequately tested. Empirical validation of solutions to perceived problems must not therefore be left to the experts, but should be tested and verified by those experiencing the problem (Scott, 1991). The notion that the newly qualified practitioner is emotionally at risk in the transition to qualified practice should thus be equally open to refutation, so that the present research study does not merely reify former value stances and positions regarding work patterns and any associated 'stress', but rather seeks to identify critical new dimensions to the debate, placing it within the much broader macro-economic context of changing work practices and contractual conditions affecting nurses as workers and workplace learners here in the UK.

The Analysis of 'Job Strain'

According to Swedish research the correct analysis of job strain must distinguish between the job *demands* placed on workers, and the *discretion* permitted them in deciding how to meet those demands (Karasek, 1979). A study conducted at the Institute for Social Research at Stockholm University resulted in the development of what Karasek describes as an *environmentally based* model of job strain.

Based on data trawled from the USA and Sweden, the consistent findings were that the "combination of low decision latitude and heavy job demands" (defined as "passive" jobs) was strongly associated with mental strain in individuals, while high demand, high decision latitude at work (defined as "active" jobs) allowed workers to deal with challenge by the development of new behaviour patterns "both on and off the job". Strain thus equals the *"excess of demands over decision latitude"*.

Karasek therefore concluded that the utility of his *environmental model* lay in the separation of job demands and job decision latitude so that, ideally, these two aspects of the job should be highly correlated: i.e. that "authority [should be] commensurate with responsibility" (Karasek, 1979:288). Using this model it would thus be possible for co-researchers in the current study to assess the position of the newly qualified nurse in relation to job demands and decision latitude, to see whether changes in control over decision-making could assist in the process of transition from novice to experienced practitioner.

Traditionally, nurses have perceived themselves as being in a high demand/low control situation, so that a collaborative assessment of opportunities for increasing control over environmental and working conditions might be a helpful line of enquiry. One of the weaknesses of Karasek's study, however, is the lack of attention it pays to the impact of gender on power relations at work. This "genderblindness" has in Clark's terms grossly oversimplified the analysis of stressors in organisations, so that when considering the nurses' gender position in the present study participants were urged to be sensitive to her plea for research which aims to understand the structural processes undermining individual autonomy in the workplace, and what she sees as the subsequent alienation of the workforce in terms of employer domination and the imposition of social control.

A major part of this *alienation* in her view is that in health authorities women tend to be treated as a commodity, and as part of "the reserve army of labour to be called into action as and when required" (Clark, 1994: 416/421). This is certainly true when the management of British NHS Trusts is scrutinised, and in the remit of managers to see that the workforce may be deployed as and when it is needed following the commissioning of new facilities (or relocation and/or closure of existing facilities) as part of the NHS contracting system. Because women constitute the largest part of the workforce in the NHS it is therefore taken for granted that it is they who will move to the whim of the market and not the system itself. The situation is more complex than this, however, in that domination is also related to the hegemony of doctors as power-brokers in the politics of health care (Mackay, 1993). There is some evidence to suggest that doctors' traditional dominance is being challenged in this respect (Witz, 1992, 1994), however, and in society more generally as the medical power base is subjected to ever closer sociological and managerial scrutiny (Lupton, 1994, Jones, 1994, Atkinson, 1995, Johnson et al, 1995).

There also remains an important (and often neglected) question regarding the position of men working in nursing at the lower end of the pay scale, so that any consideration of the gender aspects of domination must also critically analyse and assess their prospects for acquiring and maintaining appropriate learning support. Karasek's model highlights the possibility of nurses pursuing a distinction between the qualitative and quantitative job demands inherent in their work roles, and in particular draws attention to the idea that repetitious work, even if it once required skill, eventually loses its capacity for intellectual challenge.

The suggestion that the opportunity to use skill and make decisions *reduces* the undesirable effects of job demands therefore concurs with Warr's assertion that variety of non-repetitive work is essential to maintaining motivation (Warr,1996).

The problem which appears at first glance to be insurmountable, however, is that with ever increasing patient treatment and productivity targets dominating the work agenda in the NHS, nursing looks set to become even more routinized than before, with fewer opportunities being made available to meet the physical, emotional and psychological needs of patients, an aspect of the work which for many is nursing's *raison d'etre*. Even though caring is seen to lie at the heart of any self-respecting nursing curricula, this *caring imperative* (Bauer, 1990, Leininger & Watson,1990) may also be a source of conflict and emotional pain for nurses as they strive to meet the demands of care on a scale of diminishing fiscal and emotional resources.

C.Wright Mills' conception of the "cheerful robot" is an amusing but alarming one for nursing, as his vision of human beings being "turned into a robot by chemical and psychiatric means, by steady coercion and by controlled environment; [by] random pressures and unplanned sequences of circumstances" sits uneasily with nursing's declared ambition to "recentre" their caring functions as autonomous practitioners in their own right (Wright Mills, 1994: 196, Witz, 1994: 42). The chemical means Wright Mills' alludes to are in fact not so far fetched as they might seem.

One of the accusations aimed at doctors treating the symptoms apparently related to stress is the medicalization of stress and anxiety, via the so-called '*stress syndrome*', so that "contemporary medicine transforms a largescale social problem into a problem in the motivation of individuals, for which marketable commodities, including therapy programs [sic], surgery, and drugs are seen as the typical solutions" (Eyer & Stirling, 1994: 400).

Women have traditionally constituted the main focus of psychiatric intervention and experimentation in this country, and although this can be viewed through the respective feminist lenses of oppression and repression (see Russell, 1995), it has to be accepted that the great majority of women who are diagnosed as suffering from even relatively minor mental illnesses will be treated with some form of drug therapy (Foster, 1995: 90). Nurses are naturally not immune from this eventuality, so that any reported reliance on alcohol, cigarette smoking and tranquillisers is an important consideration when assessing individual nurses' methods of maintaining personal control over their lives and in the discovery of effective 'coping' strategies.

Achieving a High Control/ High Demand Work Environment

The potential for achieving and maintaining a position of *high control/high demand* in the transition from beginner to confident practitioner therefore poses a number of challenges. Adams et al (1976) suggest that there are a number of *coping tasks* which may be used to manage an effective life transition phase, namely the *management of strain* and the *cognitive task of personal adjustment*. The strategies employed by individuals to manage strain include a number of proactive strategies, which Adams et al describe as *cognitive shielding*, so that people try to guard against over-stimulation by "systematically disregarding some stimuli in the environment according to some priority scheme". The activities of filtering, queuing and approximation (such as ignoring, delaying or making hasty decisions) are likely to constitute shielding strategies, while a temporary "drop-out" or withdrawal from the situation is not uncommon.

The creation of a "personal stability zone" is seen as critical to the transitional process, with variables such as situational grouping (putting peer support to good use), crisis counselling, anticipatory socialization and the development of appropriate support systems having an attendant impact on the success or failure of the transition (Adams et al, 1976:16-17). According to this *general model of transitions* individuals are likely to move through recognised phases of attachment to the relative safety of their previous position (in this case the perceived sanctuary of studenthood), to a period of *immobilisation*, hence the "feeling of being overwhelmed" or "freezing up" when confronted by the challenges of a new job. It is the unfamiliarity of the transition state and the extent to which the person has negative or positive expectations of the work which is thought to impact heavily on this initial immobilisation phase.

If things are not handled well and complete disorientation results then the person may experience a perceived "dip in feelings"; they may become frustrated and attachment to a previous position may actually hinder them from the necessary "letting go" required of moving to a new state and their ultimate "acceptance of reality". The person begins to test new relationships and surroundings, and to seek meanings for the way things are or appear to be. Some meanings will be accepted and 'internalised', while others will continue to challenge their values or self-esteem, a picture reflected in the work of Kramer (1974) and Corwin (1961) as explored earlier in this chapter.

Adams and his colleagues go further than these authors, however, in that they claim behavioural responses to transitions are predictable using their model. In particular, they highlight the difficulties associated with *identity strain*, which they describe as a situation which exists when "an individual feels unable to implement his [sic] self image in social roles he perceives to be important" (ibid:8). This model seems to depend heavily on the psychoanalytic view of human learning, and the authors themselves acknowledge a debt to Elizabeth Kubler-Ross for her work on bereavement theory and the transition to a peaceful death which shares many of the ideas and concepts appearing in their treatise on transition management (see Kubler Ross, 1969).

Before synthesizing the above into a beginning theoretical framework for transitional learning support apropos the present study, there are three further areas which require brief examination here. The first is the contribution to be made by psychoanalysis to adult learning theory. The second is the potential usefulness of what has been described as an "underdeveloped" model of adult learning, namely that of the '*theory of margin*' (see Hiemstra, 1993).

Thirdly, it is important to assess how likely it is that striving to increase or develop social support networks through transitional learning support will actually mediate the damaging effects of 'role' strain for beginning practitioners.

Psychoanalytic Perspectives on Learning

Consider the following:

"[H]owever mature and capable we are, we continue to harbour some dread of helplessness, of being lost, overcome with fear of disintegrationwe need to test, and fear to test, whether our painfully acquired internal equipment, which is the basis of our sense of self, will stand up to the new experience or alternatively, whether the boundary of the self will disintegrate under the impact of the strange situation...we are afraid that, like once long ago, we might again be overwhelmed by experiencing helplessness, chaos, panic and being projected into a strange separate existence..."

(Salzberger-Wittenberg et al, 1983: 8)

This deeply psychoanalytic view of the human condition appears in a text dedicated to the study of the emotional experience of teaching and learning. For these authors, our problems lie in being outside of the gaze of a watchful, reliable, attentive mother, safeguarding us against harm and damaging intrusion. A school or campus can thus represent an insecure world, "a maze, an uncohesive uncontained institution", where we are afraid of potential hostility, violence and loss of identity.

Problems of transition may therefore be particularly acute for those of us who have had frequent changes of parent in childhood, those who have experienced traumatic separations or the death of a close relative, and those who "have not been able to *internalise a good enough experience* [researcher's italics] because our mothers were unable to provide a "sufficiently safe holding situation".

Thus those who are considered to be "psychically overloaded" at the time of a particular transition may be particularly vulnerable to feeling isolated and lonely, irrespective of other prevailing social conditions (Salzberger-Wittenberg et al, 1983:15).

Bowlby's Theory of Attachment

For Bowlby, evidence has accumulated which suggests that human beings are happiest and most fulfilled when they are "confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise". Bowlby's *theory of attachment* is based on the existence and presumed security of just such an *attachment figure*, and he had no qualms about recommending such a strategy to adults as well as children. Indeed, a healthy personality was in his opinion one who is able to recognize suitable attachment figures and to collaborate with them in the interests of developing a secure base and mutually rewarding relationships (Bowlby, 1979: 103-4). It could be argued here, then, that preceptorship offers the ideal attachment figure and supportive relationship required for the development of maturity and a sense of emotional security.

Without this sound base people are likely to question their own abilities, and to agonize and self-doubt to the point of 'learned helplessness' (Seligman, 1975). or in some cases to succumb to a paralysing fear of failure (Clarkson, 1994). It is not therefore difficult to divine the origin of Fry's *safe space* in the reading of psychoanalytic texts (Fry, 1987). Psychoanalysis generally appears to be undergoing a tough and uncompromising reappraisal of its efficacy and credibility in present day psychology; even so, some of the ideas it represents presented graphic and useful discussion points in the present study in its analysis of the cultural values affecting the interpersonal processes of learning in the workplace.

Limitations to the Psychological Perspective

In attempting to contribute to any critical theory of experience within the discourse of adult education the researcher would challenge Usher's baldly stated assertion that to relate adult education to learning as a psychological process is to view it as asocial and subjective (Usher, 1989:23). The framework of humanistic psychology does not in itself deny the paradox of being an individual in society. Indeed, it would seem prudent not to exchange psychology's apparent primacy of the person for the primacy of context, as this is likely to produce the same imbalance as any purely individualized account. Thus the social context for learning is an important consideration, as is the *meaning* attached to any learning.

It is not so much the increasing reservoir of experience which matters to individuals but the potential for transforming those experiences into meaning. The development of a sense of mutuality and moral value in learning characterised by Buber's *I* acting out of concern for *Thou*, must lie at the centre of any ecological thesis on human learning (see Jarvis, 1992, 1995, Friedman, 1955, Komanski, 1982).

A reflective consciousness can always direct its attention upon emotion so that emotion is seen as a structure of consciousness: emotion is not [merely] "a pure, ineffable quality like brick-red or the pure feeling of pain...it has a meaning, it *signifies something in my psychic life*" (Sartre, 1962:91). Even Aristotle is said to have favoured an inclusive analysis of emotional response (Fortenbough, 1975:21) rather than one that concentrates primarily on bodily drives and functions.

It has elsewhere been argued that social constructionism, in its purest form, involves a direct denial of both the linguistic and epistemic objectivity of theoretical descriptions, including, therefore, those of psychology. Social constructionists avow that many contemporary theories in psychological science are grounded in ideological assumptions which are then interpreted and used as "mini ontologies", which the researcher interprets as "givens" or accepted norms within a community. Thus some forms of practice are encouraged whilst others are frowned upon as part of a social, cultural, political and economic control strategy. On this account, identity and emotions are socially constructed and culturally mediated by different power structures (Greenwood, J.D.1994:38).

McClusky's Theory of Margin

The energy we are expected to draw on for meeting the responsibilities of living has also been the focus for what Hiemstra describes as an underdeveloped adult learning theory. The work of Howard Y. McClusky, an experimental psychologist and professor of educational psychology at the University of Michigan until his death in 1982, is relevant to the present study in that he devised a formula expressing a ratio or relationship between the '*load*' represented by living, and the '*power*' available to the individual to carry that load (Cabot Stevenson, 1982:222).

Margin in life represents the vitality people have for managing the load at times of transition and stress. Thus the equation of **Load divided by Power = the Margin** available for dealing with perceived stressors. A person's performance is therefore a "function of various load dimensions and values, as well as the capacity to carry that load" (Hiemstra,1993:42).

Increases in Margin are thus needed at times of 'role' overload, and in assessing whether the resources (i.e. power) available to the learner is sufficient to allow them to manage the task (load). Equally well it could be argued that an *excess* of power and a *decrease* in load may occur when the person is under-stimulated or not able to rehearse their skills, so that McClusky's conceptualisation becomes a useful formula for assessing ways in which transitional learning support, in the context of the present study, may be used to enhance both Power and (therefore) Margin.

By enhancing Power and Margin the Load (theoretically) becomes neither overwhelming nor a source of frustration for the 'learner' who is in this case attempting to practise nursing. Hiemstra argues that Margin theory can be used to plan educational and research programs [sic] based on these power and load imbalances. At the most basic level for this study, then, it is possible to envisage preceptorship providing a *counterweight* to the load presented by new learning, and as a means to increase the personal and collective resources and power of the individuals involved.

Preceptorship thus has the potential to add significantly to any accumulation of Margin, and thus to the coping repertoire of nurses in managing personal change. McClusky's equation may therefore be modified (or hypothesised) figuratively as: LOAD divided by POWER + PRECEPTORSHIP = MARGIN available for managing the personal or collective learning process.

Social Support as Mediator

The effects of support and challenge on human development are well recognised in the practice of mentoring individuals through *career socialisation*, although developmental principles for this may depend on an appropriate mix of both for the learner. Alongside these some sense of structure is required, as is the expression of positive expectations and a philosophy of sharing within the support relationship (Palmer, 1987, Daloz, 1986:214). Social support is thought to mediate the worst effects of any "distress" in the lone individual, but it is important to set this within the wider perspective of organisational gain, so that the perceived benefits (or drawbacks) of social support are recognised and dealt with as an organisational and environmental issue.

Various technical measures have been devised to assess the availability of and satisfaction with social support networks. Underlying these is the assumption that stress has an acute or chronic effect on psychological and physical health and that social support mediates this by providing emotional comfort and recovery from any perceived damage (Payne & Jones, 1995: 179).

In a review of studies which attempted to find a correlation between social support and coping abilities, these authors concluded that those who perceive "less ambiguity in their roles report more/better social support" (ibid:183). It is thought that good interpersonal relationships allow people to clarify their position/s more easily, or that supportive people will strive to reduce ambiguity for others anyway.

The 'buffering' hypothesis

The so-called 'buffering hypothesis' of social support helping individuals to buffer the worst effects of stress or illness is still widely contested, however.

Cobb (1976) argues that hard evidence exists to uphold the view that social support protects people in crisis from a wide variety of pathological states and from dependence on drugs or medication. But he also urges *caution in interpreting these findings, saying* that despite the mass of studies which have been conducted in this area, enough negative findings have emerged to challenge any assumption that social support is a panacea for all the ills afflicting modern society (Cobb, 1976:310). It has been said that previous researchers have tended to neglect the role of social support as a stress-mediating system, and that previous studies have suffered methodologically because they have seen social support as a static rather than a dynamic variable (Dean, 1977:405/411).

A Beginning Theoretical Framework

Reducing a vast body of literature into a workable framework for collaborative action research is a difficult task for any budding researcher. The best that can be achieved in the researcher's view is the assimilation of some of the general guiding principles found in the literature into a philosophical framework which reflects the overall aims of the study, and which conforms to ethical requirements for the conduct of the study in the field.

There will always be the chance that some theory or explanation was missed in the initial literature review, but at least with collaborative action research the researcher can look forward to sharing the amassed knowledge base and worldviews of co-researchers as they become 'fellow seekers after truth'.

In this way the many ideas, suggestions and suppositions which make up this framework can be put to the test, empirically speaking, by inviting the newly qualified preceptees into a community of experienced nurses (preceptors). The results can then be analysed from the perspectives of social constructionism and human ecology in order to articulate a practice based theory of preceptorship grounded in the collective experience of nurses themselves.

This emergent framework and theory is the subject of Chapter Seven. The next chapter now examines the outcomes of the present study with regard to the study's settings, participants and future policy development in preceptorship here in the UK.

Preceptorship : Outcomes of the Study

Boring holes into mountains is, by all accounts, a fairly hazardous business. To begin with, there is the density of rock. The risk of falling debris. The awful possibility that something untoward and possibly dangerous lurks within, waiting for the unsuspecting (if well-meaning) engineer to make some simple but nonetheless cataclysmic error which then causes the rock to crack and crumble, or at the very least, to resist entry; leaving the dusty and hapless prospector gasping for light and air, and wondering whether the rock is the right one after all.

Such a predicament presumably befalls all researchers to some degree when they begin to amass data, and contemplate the ever accumulating mountain of paper, notebooks, files, tapes, memos, messages, index cards, disks and the like.

For the intrepid action researcher, the data mountain is the necessary and awesome raw material from which to graft some semblance of the outcomes in a form which is accessible and can be trusted by those who contributed to its being. The action researcher must accept as a tenet that any proposed application of the analyses affects the lives of *real* people; that it is, at heart, a political exercise (McNiff, 1988:9).

As Stringer has pointed out, when people stand back from their day-to-day activities to explore and reflect on the processes in which they have been engaged, and to share their perceptions and interpretations, they tend to gain greater clarity about the direction and efficacy of their work. When it comes to an evaluation of the outcomes, however, it is necessary to focus that evaluation clearly so that it achieves its purpose:

"If evaluation includes a mass of detail that is only peripherally relevant and fails to capture the crucial elements at the core of the project, then it may be counterproductive, directing attention to the wrong areas of activity and distorting the research process"
(Stringer, 1996: 137)

Analysis and Social Constructionism

The task for the social scientist adopting a social constructionist approach to interpretation is not to gather facts and measure how often patterns occur, but rather to "appreciate the different constructions and meanings that people place upon their experience" (Easterby-Smith et al, 1991:24). The collaborative features of action research mean that participants are likely to learn a great deal from the process itself, so that their interest may be in what happens next in their project, rather than in any formal account of the research findings (ibid:8). Unfortunately for the present researcher this did not mean that considered and formal analysis could be foregone for the pragmatics of everyday practice. Some selective holes into the data mountain had to be bored, and some identification and systematic survey of the direction, depth and breadth of those holes had to be charted and documented from the outset.

As the study progressed from its initial small scale sample of 30 participants to the more ambitious and increasingly less wieldy 284 (including the primary researcher), it was obvious that, for the purposes of this thesis, the formal evaluation of the learning support model would be secondary to the primary aim of extrapolating from the available evidence the insights gained into the meanings derived from and associated with the *process* of preceptorship. The emphasis was therefore intended to be a qualitative assessment of the nature of the career transition process, rather than any quantitative analysis of the relative success or failure of the preceptorship process/transitional learning support model *per se*. However, a constructive and critical analysis of the preceptorship model did in fact take place as the happy by-product of the research.

The nature of the 'research bargain' entered into between practitioners in the field and the research student was that in exchange for the insights gained into transitional learning support by the primary researcher, co-researchers were able to develop and mould a system of peer review and development which had hitherto not been possible using existing learning support frameworks.

The situation for practitioners was relatively straightforward - they implemented the model, changed and refined it to suit local purposes, and provided a synthesis of the outcomes generated in the form of an adopted empirical model of preceptorship. This model has since been devised for use across several employers and health authorities, and as such is continuing in the best tradition of action research by carrying on long after the initial problem-solving study began. This is perhaps an example of what Hart & Bond (1995) describe as "project-based thinking", encapsulating the key components of the action research process, but also mirroring the model of daily practice adopted by health professionals in their favoured problem-solving approach, by "interweaving activities of assessment, intervention and evaluation" (Hart & Bond, 1995: 221).

For the primary researcher, the real focus of interest lay in the interactions and 'stories' produced by practitioners as they described, analysed and synthesised the views, perceptions and attitudes concerning role learning and beginning practice. Fineman and Gabriel capture the intricacies of this approach in the following paragraph:

"The tales told by new entrants to organizations are revealing. Their experiences of work are fresh and sharp; they will 'see' what older hands no longer notice or care about. An articulate, critical but naive worker can offer poignant insights on the rights and wrongs of organizational life - its passions, performances, pretences... they spotlight significant, if transient, moments in organizational life, presented with passion and authenticity..."
(Fineman & Gabriel, 1996:1)

Such stories are important and need to be heard, particularly if, as educators, we are attempting to be responsive to the needs and concerns of learners.

Generating Theory via Induction

Inductive theory is directed toward bringing knowledge into view. It is generally descriptive, naming phenomena and positing relationships, so that by alternating back and forth between cause and definition (and as understanding increases) the definitions and hypotheses and developing theory are modified (Field and Morse, 1985:6).

Empirical and practical problems or circumstances are thus investigated in order to generate evidence for which explanations i.e theories are sought (Usher & Bryant, 1989:99). The evidence derived from the amalgam of methods and sources has therefore had to be analysed and synthesised to form explanations which appear to best explain (and represent) the social constructions shared by co-researchers as to what constitutes meaningful learning support within the clinical areas and settings explored.

Issues explored by researchers included:

1. *What constitutes a career transition?*
2. *Is preceptorship needed, and if so, why?*
3. *What impact (if any) do such transitions have on adults' emotional lives?*
4. *How can the interpersonal and emotional facets of learning at work be made more explicit to those involved?*
4. *How are the emotional aspects of such learning managed and dealt with in the workplace/learner communities?*
5. *What, if any, cultural values predominate in the workplace, and what implications do these have for continuing education and learning support practice generally?*

Preceptorship and 'Vocabularies of Emotion'

One of the most striking and surprising things about this study has been the development and assimilation of a vocabulary for dealing with the emotions generated by career transitions such as entry to qualified practice. Although the researcher had assumed that such a language of sorts existed, and that it would emerge naturally due to the study's emphasis on the part played by emotions; she was not prepared for the extent to which participants would respond to appeals for 'emotional data', and for the catharsis provided by the research for the relatively free and unrestrained expression of emotions generally regarding the experience of nursing work.

Earlier reading of studies and texts relating to 'emotional labour' (e.g. Smith, 1992, Hochschild, 1979) had sensitised her to the possibilities of strong emotion or frustration being expressed as part of coming to terms with new expectations, but as so little attention is given in the research literature to the emotional involvement of researchers in their fieldwork, she was genuinely not prepared for the poignant, at times distressing, and often moving disclosures which emerged as part of the collaborative interaction with co-researchers at an interpersonal level.

On reflection, this is perhaps somewhat ironic. After all, how could learning possibly be studied without engendering an emotional response from researchers? How could any research student expect to remain outside of this catharsis, given that she had shared similar experiences and situations? Much hinges, here, on the placing of the self. Just as participants were expected to examine their professional concepts of 'self', so the researcher was forced to examine her personal position, and to account for it and justify her value stances as did every other person involved in the study.

This was at times a hugely enlightening activity which allowed the researcher to reflect not only on her beliefs and practices as an educator and researcher, but also as a (potentially) influential member of the social interaction process.

The use of 'personal stances' in learning

Because it was thought necessary at the beginning to devise some way of gaining a rapport with co-researchers, a particular approach was adopted by the researcher because of its personal appeal, and because it seemed to promise a kind of engagement with co-researchers which would make frank and open discussion of the issues possible. Described by Salmon as *personal stance theory* (Salmon, 1989:230), this theory is an attempt to help learners understand the ways in which they construct their own unique material for learning. What is said to be distinctive about this approach, according to Salmon, is the way in which 'personal stance' as a learning concept gives paramount importance to the personal position of learners. She argues that it is through the stance which we take up in any situation that "we give our own distinctive meaning to what it involves". Those acting as teachers, she says, must remember how critical our own stance and position is to the limits and possibilities of our engagement with learners (Salmon, 1989:231). When applied to the context of a research study, the stance of the researcher is thus critical to any responses or engagement with participants themselves.

As Salmon was preparing to address a conference on experiential learning she invited participants to note down their personal perceptions of her. On the basis of their preliminary acquaintance, what kind of person did she appear to be? Then she asked them to think about these perceptions as referring to their own personal stance towards her as an individual.

Ostensibly her purpose was that of the traditional academic lecturer; to introduce new ideas and new ways of looking at the world. What she had in fact managed to do was to interact on a personal level with every person who listened; to generate the basis of a relationship which immediately captured the 'personal'. From that moment on, the dynamics shifted from the distant position of conference and delegate to that what Salmon describes as "the teacher-learner encounter"(ibid:232). This apparent intimacy - and the very personal nature of the invitation - illustrated her point perfectly: which is that in order to establish trust between individuals it is sometimes necessary to introduce an element of personal risk to the encounter, to let learners see the teacher's vulnerability, so that they do not feel outsiders in the learning relationship.

The need for trust and reciprocity within groupwork

For the researcher looking to establish a relationship of trust and reciprocity in the 'field', this appeared to be an ideal strategy for gaining the confidence of those who would, at the beginning, be virtual strangers. It was using this theoretical base that the present researcher devised a technique for use at the beginning of exploratory groupwork. For example, on being introduced to a group for the first time, participants were asked to consider the stance of the primary researcher and to write down on a slip of paper their first impressions of her as a person. They were reassured that they could be as frank and forthright as they wished to be; that all comments would be kept confidential, and that the researcher would not take offence in any way from the conclusions drawn by individuals. Co-researchers were also asked to keep the exercise confidential to their particular group.

While participants were considering this request (and generally looking bemused at this rather eccentric departure from normal pre-course introductions) the researcher then asked them whether they objected to her removing her shoes and donning "comfy house slippers", so that the atmosphere could then be relaxed and informal. This was (generally) considered to be even more eccentric, but it did in fact have the desired effect, which was to suggest to participants that the group discussions and activities were to be conducted in an atmosphere of informality and psychological 'safe space'.

By laying herself open to the critical analysis of participants and inviting personal comments to be made, the researcher implied that an element of trust was required for the conduct of the workshops. If the researcher trusted participants not to be too insulting to her personally, then they too could risk making personal disclosures or saying things they might otherwise feel inhibited from saying within the emotional safe space created by the group. This approach came to be known colloquially (and somewhat drily!) as "*the slipper technique*", and to all intents and purposes worked well.

At the end of the two day workshops when all participants had come to know each other well, the comments on the paper were read out to the group, who were then asked if they could identify the purpose of the exercise. Invariably comments received confirmed the researcher's risk hypothesis: that in order to feel safe the person leading the workshops needed to surrender some control over the proceedings: to give participants the responsibility (and a share of the power) for conducting the workshops in a mutually supportive manner, respecting each person's individuality and the right to explore feelings and issues in a constructive way.

This was recognised as a high risk strategy for the researcher, as misunderstandings or potential problems arising from the use of the technique might well have jeopardised the chances of gaining the confidence of co-researchers at an early stage. Fortunately, no such problems arose and on evaluation of the workshops the technique was viewed very positively as a helpful way of reducing anxiety on the part of individuals, many of whom had anticipated a much more structured and didactic approach, and who were subsequently relieved at the atmosphere of collegiality and mutual interest which evolved over the two day period.

The following examples are comments regarding the personal stance and first impressions of the researcher written by participants in one group having come together for the first time:

"Voice seems relaxed but feet movements appear to say you're a little nervous. Wants to make everyone feel relaxed and not to intimidate as she's the one with the knowledge"

"Appears to be friendly and relaxed. It should be an interesting and informal two days"

"Academic. But why did she find it a problem with the overhead projector? Must have used one hundreds of times. Friendly, despite not knowing many"

"Relaxed, calm, quiet, clear, strong, confident, listener, self-aware. Likes people"

"Very intelligent, knowledgeable, confident, able to put people at ease"

"You come over [a] lot quieter and more serious than you really are. Easy to talk to and be with"

"Relaxed and obviously well used to the role of tutor. Softly spoken and I feel the need to listen closely to ensure I'll hear everything. Needs to feel comfortable, hence changing of boots into slippers"

"intense, interesting, warm, friendly"

"Relaxed, informal, pleasant, adult, giving - nice personality - confident, supportive, gentel, [sic], open, receiving, ready to listen, ready to share"

"Appears friendly, open, cheerful, extrovert [sic], knutt case [sic], approachable"

Clearly, the exercise had achieved its aim of capturing the attention and confidence of participants. It was, however, something of a feat for the researcher who is not at all personally confident as a public speaker, preferring to address larger rather than more intimate or medium sized groups. The trust element of the exercise had also taken hold in that none of the comments were anything other than friendly and complimentary. Some of the participants had undertaken psychiatric nurse training, so that some may have been wiser than others as to the real purpose of the exercise.

Replies may also have been affected by the *"halo effect"* acting on the study generally, i.e. the positive publicity and interest generated by the study mixed with the generally poor morale of the group. Here was someone expressing an interest in individuals who already felt vulnerable (and for some) abused by the massive reorganisation of the health care system. Not only did she want to listen to what people had to say, she was offering them some glimmer of hope in coming to terms with the changes imposed upon them. Thus the researcher unwittingly was setting herself up as something of a "prophet of false hope" within the health care scenario, a position which was to gradually become more difficult as mutual involvement in the study continued over months and then years. The impact of this on the study and on the individuals involved is discussed in more detail later in this chapter, under the heading "Contemplating the rubble", when the aftermath of data collection and analysis is analysed more fully.

Emotions and Work Entry: the Importance of 'Significant Others'

When asked to relate their experiences of being a newly qualified nurse, co-researchers expressed strong views on the transition from student to accountable practitioner. Feelings and emotions associated with the transition and change in role were shared by participants after discussion in small groups, and a representative sample appears below.

"pressurised" "threatened" "uncertain and anxious" "felt left to get on with it - no positive feedback only negative" "knew I was doing alright when nobody shouted at me" "fear" "was very frightened" "felt conspicuous and uncomfortable"

"demoralised" "insecure" "confused" "overwhelmed" "lacked confidence and assertiveness" "sick to the stomach - had real abdo [sic] pain and insomnia" "fear of the unknown" "concerned about new responsibilities" "scared of initiating things and being in charge of the ward" "felt a desperate need to belong" "relief at having achieved the ambition to qualify!" "undermined and demoralised by managers" "felt there was no light at the end of the tunnel, lack of resources on-going, no answers and no solutions offered to the problems encountered day in day out" "felt like a mushroom being kept in the dark all the time and being fed on...." "professional standards undermined by know-all managers" "conflict from the organisation, the profession and from personnel always wanting you to do things you couldn't do"

"felt the lack of experience as a student [and] ended up being told "don't think - just do" "dropped in at the deep end" "intimidated by senior doctors" "unprepared after days off, handovers [reports] often poor after days off leading to a feeling of insecurity and chaos" "I was suddenly accountable for the actions of the students when I wasn't even sure [of] what I was doing myself" "constant fear that somebody will arrest or die" "scared of talking to relatives who'll think I'm incompetent"

"relatives' expectations put pressure on you" "relatives know their rights better than I do - I'm aware that they can lose me my job" "scared to approach senior staff in case they think I'm silly or stupid" "fish out of water" "lonely" "everyone seemed to know more than me - including the patients!" "lack of reward" "didn't feel appreciated or recognised for the work I did" "hated being relied on too much" "never enough time to do everything" "unco-operative staff made life difficult" "got fed up with inconsistent management, one minute laissez-faire, the next autocratic".

The counterbalance to these overwhelmingly negative replies came from the small minority of participants who saw the experience as a positive one. Their comments included:

"liked the status being qualified gave me" "enjoyed the sense of achievement" "impressed my friends with my new position" "felt motivated and enthusiastic" "felt happy after the worry of qualifying" "felt important, knew I mattered suddenly" "felt it was character building" "nervous and excited at wearing the uniform"

The overwhelming majority of participants cited guilt as the main feeling induced by nursing work. Staff shortages and high expectations of those staff who were working led to feelings of vulnerability and impending crisis, fear of what might be *"just around the corner"* and a perceived need to be *"seen to be"* in control of whatever happened within their wards or working environments. Nurses working in the community were especially vulnerable here as they often attended patients alone and felt the burden of being able to respond to whatever demands were made on them.

Nurses working in high dependency areas seemed to fare well because the staff-patient ratio was higher, and because there was generally a more experienced and well qualified person around to approach for help and clarification. Nurses in theatres appeared to be the most exposed to negative and demoralising experiences, however, with one nurse encapsulating the feeling of many when she said:

"Hell's bells and buckets of blood...the psychology of warfare is what it is. What I want to know is why are we at war with ourselves?"

The experience of being undermined and belittled by nursing colleagues and "being left to fend for ourselves" was particularly strong in theatres, with a feeling of competitiveness being expressed between teams of staff allocated to different theatres or tasks within the theatre complex. This was not exclusive to theatre staff, however. It also occurred with staff working in accident and emergency (A & E) services, although much seemed to depend on the management style of the person in overall charge, either the A & E manager or the casualty consultant. Where junior doctors were considered to be helpful and considerate the reports were more positive and this held generally across all cohorts and areas of care. Where junior doctors were thought to be equally out of their depth, respondents expressed some sympathy and/or empathy for the doctors' position, but expressed concern and resentment that nurses should be expected to make up the shortfall for the doctor's lack of experience or know-how:

"It's not like we're experienced or anything. They look to us for help and if they don't get it the first time they tend to think we're not up to it and ignore us when we do give advice or make suggestions..."

The quality of the relationship between doctors and nurses seemed to be an important indicator of the overall ethos and atmosphere in the workplace. Although it was expected that the senior consultant or the ward manager would be an important influence on this process, in reality participants expressed the strongest feelings about those staff who were working closest to them. "*Cliquiness*" and "*taking over because they're quicker*" was frequently cited when participants were asked to identify what had specifically *helped or hindered* them. For staff who had taken up appointment in wards or areas where they had previously been allocated as nursing students the relationships were generally more stable and positive, presumably because they had based their decision to apply for a job on earlier positive experiences.

Again, however, this could not be relied upon, as staff changeovers and turnover, ward re-organisations and variable levels of sickness absence sometimes meant that strategic changes had to be made on an ad hoc basis. Newly qualified nurses expecting one scenario were therefore not always guaranteed the colleagues they had anticipated. This seemed to add to the isolation felt by new staff, and was particularly acute where staff were expected to fill in for colleagues working in other areas on a casual basis. The unfamiliarity of the surroundings and the idiosyncrasies of ward routines loomed large for the inexperienced nurse who was attempting to fit in to the prevailing system, and lack of time to attend to the details of particular environments seemed to lead to a feeling of disorientation expressed as "confusion" or "fish out of water" analogies.

When asked to describe individuals who helped or hindered their transition to the new job, the picture was equally vivid:

Hindrances included:

"unapproachable staff" "grouchy, hard-pressed doctors" "people opposed to change and suggestions for change from the newly qualified" "consultants who throw their weight around" "lack of knowledge about the role" "being frightened of being accountable" "scared of the legal consequences, kept checking and cross-checking everything [un]til it drove everybody mad" "bossy relatives" "warned not to step out of line" "trained [experienced and more senior] staff unable to take criticism or open their eyes to new ideas" "felt theoretically confident but practically useless" "didn't always feel confident about the consequences of certain actions" "felt like work was an initiation test" "felt like I had to prove I wouldn't be disloyal" "scared to own up to my mistakes unless I heard somebody else do it first" "paranoid about cliquey staff"

The task of identifying those individuals who had actively or indirectly supported the transition process was an enlightening task for participants as many were reflecting on the process publicly and privately for the first time.

By far the most supportive 'significant others' identified (contrary to the literature on the role played by the traditional ward sister in the past) were the army of unqualified but very experienced staff on the wards such as support workers or nursing auxiliaries. The consensus seemed to be that if you gained the confidence of the most experienced support worker then your position was that much more secure. Gain his/her poor opinion of your abilities and your problems would magnify accordingly!

Ward and other senior managers did not really figure at all in participants' analyses of significant others, other than negatively.

Feelings associated with managers tended to centre on whether resources were managed effectively or ineffectively, or whether more senior staff sidelined the newly qualified nurse in preference for other colleagues. Provided managers took only a friendly and pastoral interest in the newly qualified (by implication not interfering in the day to day work of the nurses) they could "*just about be tolerated*" as a part of the workforce. Should a manager intervene in some way, perhaps by commenting on the performance of the new member of staff, then managers were deemed to have a potentially punitive impact on the individual. Contact between the very senior and/or experienced staff did not seem to be expected or encouraged: rather, considerable distance between the two appeared to be the preferred strategy as far as the newly and recently qualified were concerned.

Conversely, where managers were unable to recognise and acknowledge new members of staff or remember their names they came in for particularly vitriolic criticism for not being "in touch" with the grassroots level of the service. This seemed to be something of a contradiction in terms. Managers' interest was effectively discouraged while their apparent disinterest was condemned as a lack of care or concern for the staff "who were keeping the service going". This hinted at a more complex role for nurse managers than has perhaps been appreciated or evident in the literature, and seemed to suggest that the transition from service to business manager within the recently derived consumer ethos of the NHS is having more subtle effects on the culture than has previously been realised. Other helpers in the transition process included friends, neighbours, family and colleagues working within the new nurse's own team. Personality clashes between colleagues did not seem to be a huge problem, although where these were expressed the impact seemed to have fairly devastating consequences for the individuals concerned.

It soon became clear that opportunities to resolve these personality conflicts would be an important aspect of any learning support provided. Given changes in clinical leadership and the development of flatter organisational hierarchies within the health care system, not all problems depended on the actions, opinions or responses of the most senior members of staff. The legendary power of the traditional ward sister/charge nurse appears to have dissipated somewhat in this regard, with nurses expecting to have more say in the decision-making processes associated with the management of care.

Significant others who were singled out for particular praise were those experienced enrolled nurses who had not yet converted to first level practice. Their fund of knowledge and practical experience of ward routines, familiarity with procedures and established position within the health care team meant that they were in a solid position to offer support to the newly qualified. Unlike their staff nurse colleagues they appeared to feel less threatened by the presence of the newly qualified, perhaps perceiving the new nurses' worries about being able to deliver care effectively in the light of educational reforms and perceived inferior practical experience in relation to their newly acquired theoretical knowledge base. Enrolled nurses seemed to be particularly skilled at appearing at the new nurse's shoulder just as an 'experienced hand' was needed.

The outcome of this was sometimes negative, however, as it had a tendency to make the newly qualified feel even more inadequate, by appearing to confirm cultural prejudices and beliefs that the new system of nurse education in higher education institutions was *"not working and not all that it's cracked up to be"*.

In this sense those newly qualified in the last seven years have been put into the unenviable position of having to defend their formal standards of pre-registration preparation (i.e. Project 2000) as well as their own performance in relation to earlier traditional methods of training. Examples of this competitive attitude emerging between traditionally trained and diplomate nurses included *"if you suggested something different then it was a third world war"*, *"she came to us qualified never having taken a blood pressure"*, *"she told me she hadn't come into nursing to deal with patients but to lead from the front. What kind of nurse is that can you tell me?"*. *"I didn't get A levels just to empty bed-pans"*.

The most positive comments came from staff who had decided to call a truce over this particular argument and those who *"saved face"* by recognising the contribution to be made from both traditionally and recently qualified staff, arguing that what one lacked the other could rectify in the best interests and practices brought about by team working. One ward even incorporated this ethos into its published philosophy of care by claiming to uphold a *"shared learning ethos"* between staff across the multi-disciplinary team.

With respect to other factors which were thought to help the transition process several other critical strategies emerged. When asked to put forward their own successful strategies for dealing with new role learning some offerings were decidedly tongue-in-cheek: *"Benson & Hedges & Holsten Pils!!"*, *"fags, snooker and long nights out"*. It was interesting to pick up the gender issues here, in that the men were much less comfortable about discussing their experiences or feelings openly. With the notable exception of critical incident analysis, which all participants took very seriously, the men seemed to be more comfortable with a lighter, more humorous approach to disclosure than was usual in other all-female groups.

Some groups were markedly more sensitive to these nuances of feeling than others. For example, where more than one man was included in the group the discussions rarely veered into the expression of acute feelings of sadness or bewilderment. Frustrations tended to be framed in the language of conflict with the frequent expression of anger, disgust or even betrayal from the men, in sharp and distinct contrast from the guilt-edged responses of female participants. For the men, the problems were attributed to a faulty and uncaring system; for the women, it was more a question of feeling guilty for their own inadequacies in coming to terms with their new roles. This had echoes of the body ownership problem alluded to by Gergen in chapter 5, where men are said to blame their bodies for going wrong, rather than seeing them as integral to their concepts of self. This psychological distancing from the problems in hand may therefore be a part of the reason why men who are nurses are seen to be aggressive. What may be no more than a protective defence mechanism against barrages on the male self may therefore be taken to signify aggression when compared to the more inward looking and unassertive stances of the 'female' nurse.

Selflessness and the service ethic

It is here that the concept of self seems to acquire significance. In particular, the expectations on nurses to be *selfless*, as a legacy from the Victorian ethos of nursing as a spiritual and practical vocation, is relevant to any useful discussion concerning espoused and practiced values in the workplace. When considering issues of the self and social order, sociologists would see this as an issue of *ascription*, as one of the facets of the nursing 'role' ascribed to it by virtue of its recent history. Thus while some roles are ascribed by virtue of a person's sex, age, religion and ethnicity, some are achieved or acquired through credentialling or through familial and social expectations.

Role-making and *role-taking* are influenced by the specific ideas people have about "proper, normal, and expectable [sic] conduct for boys or girls, men or women" (Hewitt, 1994: 127), and presumably [in this case] by those enacting and participating in this thing we call 'nursing'. The shift from traditional notions of selfless giving required of nurses in the formative Nightingale era of the 1860s, to the development of what has recently been described as the "new nursing", has involved a redefining of the meaning and boundaries of the nursing 'role', so that:

"the meaning of nursing care appears to be shifting from the requirement of nurses to understand and address the patient's needs (caring for), towards a broader interpretation which includes both 'caring for' and 'caring about' [patients]..." (Savage, 1995: 51)

This implies a much stronger political emphasis on the part played by the nurse as patient's advocate, so that the apparent aggression expressed by the men in the present study need not necessarily be 'male' at all, but rather constitute new evidence to illustrate the culture shift nursing is currently experiencing in its drive for professional autonomy and status. It should also be mentioned, however, that men in the present study saw themselves (in the main) as *bi-cultural troublemakers*, (after Kramer, 1974) charged with the task of "bringing nursing into the 21st century", of assimilating the qualities and attributes of the "new nurse" with the more openly competitive and market-oriented system of health care being offered. They appeared to share the same high aspirations and commitment to patient care as did their female colleagues.

The difference seemed to lie with different conceptions of "service", hence rather than adhering to notions of *servility* and humility- a position favoured by the 19th century traditionalist ethos- they preferred to conceptualise nursing as a "service" in much the same vein as other services within the more contemporary idea of "service sector employment".

This also highlighted the potential conflict to be experienced by staff attributing different cultural values to the idea of providing and maintaining aspects of service provision. For some, nursing was about supervising and directing care holistically and with regard to ethical principles; for others, it was about maintaining a good nurse-patient relationship.

This was the first of several areas of conflict to emerge in the study between participants, and it marked the beginning of the important exploration and clarification of values which was to constitute the next stage of the investigation.

Confronting the 'aha'

After considerable discussion and debate the the likely candidates best suited to act as preceptors were in fact enrolled (i.e. second level) nurses. This constituted an immediate dilemma. The statutory bodies for nursing, midwifery and health visiting had already decreed that only experienced *first* level nurses could act as preceptors. On balance, the evidence we had acquired to date suggested that they were in fact possibly the worst candidates for the role!

How were the action researchers in the present study to address this problem, and arrive at a satisfactory solution for all concerned? It was now becoming clear to the first level staff nurses acting as co-researchers that *they were themselves the problem* confronting the newly qualified. Having assessed and found their staff nurse and more senior colleagues wanting in the business of providing transitional learning support, they now had the thorny problem of raising awareness and changing attitudes within their own ranks in order to improve morale and opportunities for learning on entry to nursing.

For this to happen, the old traditions and hierarchies of the past would have to be effectively challenged. How did co-researchers feel about this 'aha', this sudden flash of insight, and how enlightened did they expect other colleagues to become in the light of this new-found knowledge?

Availability and trustworthiness of supporters

A closely related key theme emerging from the discussions which might throw light on this dilemma, and which was later underlined by data acquired from personal interviews, was that of the accessibility and trustworthiness of colleagues who were expected to help support the new member of staff. Where a member of an existing team had been specifically allocated to the new nurse high expectations were raised, and generally dashed, when shift and problems concerning lack of time together intervened. The choice of individual supporter was generally left to the discretion of the ward, unit or area manager, and no specific criteria for choosing the person (other than availability) could be found.

Some managers considered it appropriate for supporters to be recognised assessors and teachers, but as the workload of assessors was already heavy, individual supporters could not always provide the guidance or help required in a form appropriate to the new member of staff. This led to disillusionment with the support process, and to new staff seeking out their own informal 'survival' networks. Again, responses were almost always negative.

Even when asked to identify factors which enhanced the transition or which "made life easier", co-researchers had a good deal of trouble in articulating what these people or strategies might be.

Responses ranged from *"always one member of staff who is unapproachable and unkind"*, *"abrupt relatives can make your life miserable"*, to the (slightly!) more encouraging *"filling me in on the ward gossip was a help - I knew who to avoid, then"*, or *"demands changed with putting on the staff nurses' uniform, the doctors didn't expect any different [from you], you might have been qualified for five years or five minutes it was all the same to them"*.

The night staff came in for particularly bitter criticism:

"No-one said what happened on nights, so when I went on for the first time I was late doing the drugs [round]. Night sister came on demanding to know why I was still doing the drugs at 11.30 [p.m.] I burst into tears - I felt I'd been up to something I should'nt be doing. I avoided her in the future, she was so nasty.."

Hopes pinned to support from other staff sometimes had unexpected consequences:

"It was better to get on and do it, rather than thinking about it. I had the problem moving from kids [paediatrics] to the medical unit. The change was horrendous, nobody helped but the auxiliaries. I was allocated a mentor - another member of staff - but after the fourth shift on that fell apart. The sister was very good giving me an idea about what she expected and the [ward] procedures and so on, but it was the EN [enrolled nurse] who took me under her wing. Told me the gossip and who not to rub up the wrong way..."

"The old dragon of a ward sister everybody'd warned me about sat me down and said that I wasn't to take everything to myself. She said that if things didn't go quite right then everybody had a share in putting it right. She wanted to be the first, not the last to know. That was sort of reassuring for me, knowing that somebody was looking out for me and wouldn't be surprised if it didn't fall into place right away".

Discussions concerning the rights and wrongs of practice and the example set by more experienced staff tended to focus on the identification of an empathetic person who would "be there" for the new nurse. The skills required by the beginning practitioner therefore included the ability to differentiate between a "good" role model and one who would be "a bad influence", or have a negative effect on their self-confidence and morale. However, when asked how new nurses could be expected to tell the difference between good and bad role models, co-researchers had some difficulty in formulating a strategy for their preceptees. The concept of 'role' was problematic and difficult to adequately articulate. It was also unsatisfactory in that no description of what a role constituted was found to be sufficiently comprehensive for all tastes. Despite this, however, it seemed to offer an interim solution. To begin with then, co-researchers put into words what they saw to be characteristic of a positive role model.

These are listed below, with the most commonly described characteristics appearing at the top of the list, and the least commonly cited at the bottom.

Characteristics of a Positive/Desirable 'Role Model'

- *approachability*
- *accessibility*
- *is calm and in control*
- *sense of humour*
- *kind to patients*
- *has high standards [of care]*
- *is a safe practitioner*
- *is up to date*
- *is well motivated*
- *can be trusted with personal and or confidential information*

- *is understanding*
- *has empathy*
- *is adaptable*
- *has a friendly personality*
- *has a smart appearance*
- *is assertive and a good communicator*
- *has good leadership skills*
- *is somebody you would like to be like*
- *is someone who can justify their actions*
- *is knowledgeable and clinically skilled*
- *keeps a professional distance*
- *is firm but fair*
- *inspires confidence*
- *is truthful and commands respect*
- *has organisational ability*

Qualities which were also described concerned the ability to admit to or "*own up to mistakes*", to be someone "*who follows guidelines*", who is "*research-minded*", who "*sets a good example*"; someone "*who can prioritise efficiently*" and "*pull their weight*". By contrast, the characteristics of poor or undesirable 'role models' were:

- *those who "broke the rules"*
- *bad listeners*
- *dressed sloppily*
- *saw patients as a burden*
- *those who were quick to criticise*
- *those with an abrupt or "superior" manner*
- *those who "badmouthed" the system or each other*

Enabling/Disabling Strategies

Palmer would view these different characteristics as *enabling* and *disabling*. The most effective supporters in her view would be those who are open and constructive, and who enable by being accessible, responsive to the needs of others, easy to trust, are comfortable with themselves and their abilities, and are able to command mutual respect. Disablers, in contrast, are inaccessible, throw people into new roles using 'sink or swim' strategies, refuse requests, over-supervise, destroy by 'dumping' on another person, or by openly criticizing them in front of their colleagues. In addition, however, there are the all important and influential "enabling disablers" or "enabling manipulators" who appear to be helpful superficially, but whose actions of creating tensions and disruption exert a much more subtle, but equally devastating effect as rank disablers on individuals by seeming to provide support when in fact they covertly undermined them and their position.

This categorisation of enabling-disabling traits was a very helpful one for the present study, in that it allowed co-researchers to frame helpful strategies from a *non-manipulative, facilitative* point of reference, building on the positive attributes while taking into account the need for supporters to appear human in the eyes of anxious neophytes (see Palmer in Morton-Cooper & Palmer, 1993:49-51 for a full discussion on these issues).

Clarification of the differences between good and bad role models could be acquired through sensitivity to enabling/disabling traits, so that the over-riding issue for the staff nurse or colleague trying to provide support was "Is this an enabling or disabling thing to do?" This had obvious implications for staff who liked to dominate or bully less experienced staff, or who added to their uncertainties by undermining their new found authority as a qualified member of staff.

'Feelings Management' and the Issue of Control

Another of the themes which recurred throughout the study was that of 'feelings management', of coping with the emotional onslaught brought on by caring for others, and for maintaining some sort of emotional equilibrium in the face of constant demands for attention. In examining the connections between role enactment and moral sensitivity, Scott (1995:328) comments that health care practitioners should recognize that "in taking on the role of nurse or doctor she/he is taking on a particular role with identifiable rights and duties". Scott contends that the relationship between role enactment and moral strategy should be stated more explicitly than it is at present, so that new practitioners have a more realistic expectation of the role intended for them. Patient well-being depends on the skill with which practitioners are able to empathise and care for them. Understanding and sensitivity to the patient's uniqueness is critical to the success of care delivery:

"For those working in areas such as caring for the old or long-term sick people it soon becomes apparent [] that the way in which medical and nursing staff relate to and interact with these patients can mean the difference between patients retaining a sense of reality and a normally functioning personality or feeling forced to revert to childish manipulation or the throwing of temper tantrums in order to gain some sense of control over their environment" (Scott, 1995b:326)

The need to stay in control of this work environment, to be able to respond adequately to the daily round of physical and emotional demands pressed on them was, as had been hinted at in the literature review, an over-arching theme of the nursing discourse engendered by this study. At the heart of this lay *fear*: fear of failure, fear of "letting the side down", fear of failing colleagues and patients in the necessary life-saving or life-enhancing activities which made up the work of nurses. Above all, lay the spectre of *accountability*, a fear of the responsibilities surrounding *accountable practice*.

The nurses within this study set themselves extremely high standards and then seemed prepared to punish themselves and their colleagues if such standards were not maintained. Accountability, it was concluded meant "*being able to justify your actions*", "*being answerable to others for your actions*", "*taking the rap for what goes wrong*".

In attempting to raise standards within nursing the statutory bodies which were created in 1983 following on from the 1979 Nurses, Midwives and Health Visitors' Act would therefore appear to have succeeded in their drive to make nurses respectful of their many responsibilities and duties. In a recent textbook on accountability aimed at nurses Chalmers states:

"Accountability thrives in professional groups with a sound knowledge base, with a high level of skill, with a clear commitment to improving standards and with the maturity and confidence to tackle difficult decisions knowing that there will be management and professional support. Accountability flounders where there is inadequate knowledge, underdeveloped skills, little motivation, a lack of self-confidence and a fear of reprisals. The exercising of accountability is an indication of a professional group that has reached a certain maturity and values accountability as the necessary means of building on that maturity."
(Chalmers, 1995: 36)

On the face of it, a lack of professional and managerial support are to blame for not allowing nurses to achieve their aims. An examination of the policy and management literature, however, shows that managers and more senior practitioners grapple with the same problems as their more junior colleagues: ill-defined 'roles', a mismatch of employer/employee expectations, constant shifts in policy, and feelings of exasperation at not appearing to meet the demands made on them. Again, the social construction of 'role' delineation and the creation of consensus over what constitutes meaningful role boundaries is thus open to question.

An over-weening emphasis on managerial effectiveness and performance management has led managers to search for ways to increase "situational sensitivity", so that "the manager is helped to develop the capacity to interpret his or her situation accurately so that they understand fully what is expected of them, and is then helped to enhance or develop the skills and capabilities that will allow them to meet those expectations" (Flanagan & Spurgeon, 1996:20).

The problem with this approach is that it assumes that some sort of natural order is both possible and achievable, even under difficult and challenging conditions. The evidence for nurses involved in this study refutes this assumption absolutely.

As Brykczynska (1993) has commented, "When value systems conflict between an individual and the collective or the institution or profession, then *inter-personal moral distress* may develop" (Brykczynska, 1993: 137, researcher's italics).

Thus the demand for order in the face of massive structural *disorder* (even if, as we might argue, such disorder is only one possible social construction of the situation), places a heavy burden on health care practitioners, particularly when it is realised that they are expected to serve many different metaphorical 'masters', i.e. patients and their loved ones, managers, colleagues, the professional ideal, their own professional self-image/ concept, their families, friends and 'society' generally, in the UKCC's standard exhortation that "Each registered nurse, midwife or health visitor, shall act, at all times, in such a manner as to: safeguard and promote the interests of individual patients and clients; serve the interests of society; justify public trust and confidence and uphold and enhance the good standing and reputation of the professions" (UKCC, 1996:8). On reading the UKCC's document on accountability alone it is easy to see why nurses are doomed to failure.

Selflessness is still required of them as the 21st century approaches, to the point of "making sure that you put the interests of patients, clients and the public before your own interests and those of your professional colleagues" (ibid: 9).

The UKCC's recently amended Guidelines for Professional Practice (1996) go on to pile yet more pressure on practitioners by clarifying their responsibilities for making managers aware of shortcomings in the work environment. Yet where nurses have effectively 'blown the whistle' to attract attention to poor practice or working conditions, 'the system' has been largely unsympathetic to their cries for help, with attempts to 'scapegoat' and demean the individual, so that "raising justified grievances may put their posts in jeopardy" (Dimond, 1994:70).

Dimond warns that staff who whistleblow cannot necessarily look to their colleagues for support, as strike action or any industrial work-to-rule is not ethically acceptable to many practitioners and is probably in breach of the UKCC Code of Professional Conduct anyway:

"There are no signs that the UKCC is able or prepared to take public action for those practitioners who find themselves in a Catch 22 dilemma. This is a serious situation and one which should be considered by the Government and the statutory bodies in order to ensure that standards are maintained."
(Dimond, 1994: 70)

If accountability has therefore not been welcomed by nurses, as Chalmers decrees, it is no wonder and no surprise as to why (Chalmers, 1995:37). There is precious little escape for nurses under the present system, so that the venting of emotions is an unwelcome adjunct to the steady and (it would appear) unrelenting pressure to conform to the "*put up and shut up*" philosophy which constitutes the hidden curriculum in nursing work.

As the economist Catherine Casey has maintained, this may be evidence of the change from industrial to post-industrial forms of work. She argues that the primary impact of work is no longer on the body, the need for physical prowess demanded by bodily exertion and created bodily fatigue, but rather the post-industrial requirement for capturing "the quick, attentive, trained mind", for example, in the cult of the corporate identity. Even at the low-paid, lower- skilled end of the service sector where the stamina to do physical work is still needed, additional skills of 'personality', 'congeniality' good humour and interactive skills are also required:

"The discursive or communicational practices of work not only socialize "normal" adaptive workers into work tasks and habits, they fundamentally affect one's emotional and psychic processes, sense of well-being and identity"

(Casey, 1995:86)

Taking this a pragmatic stage further then, nurses not only have to put their hands and heart into their work, but their souls are required as well! The difficulties are again expressed in the language of subordination: what Perry has described as an occupation viewed as an imposed rather than negotiated order. As far as Perry is concerned, nurses are not employed in the health service to express themselves, but to manufacture a system of caring. As the sole intermediary between doctor and patient nurses fulfil a particular function. To re-examine the quotation from Perry cited earlier (p.55, chapter two):

"Doctors need clever pairs of hands to assist them in their technical tasks. Hospital administrators need well-regimented pairs of feet which respond in uniform ways to different marching orders and constant changes in the battle plans. Patients need human compassion, carers who respect them as persons and not as bodies. All these groups want what money in a money economy does not necessarily buy. They want the *love* of worker bees, with their dedication of purpose, superb instincts and organisational skills. Who tries to live up to these almost impossibly high and unstated expectations in human caring and who therefore suffers the personal consequences of failing to meet all these needs? Usually nurses in health and usually women in the family and society generally". (Perry, 1993:62)

This implies that nurses need to devise strategies for maintaining personal control over the physical and emotional demands placed on them, and ways of subverting the damaging effects of too little control in their everyday working and learning environments. One such mechanism devised by co-researchers for this study is described below.

Problem-solving by the Introduction of 'Stressometers'

When asked to name the aspects of beginning practice in nursing which caused them concern, nurses within the present study constructed various models of analysis, including an illuminating and easy to use '*stressometer*'. Drawn figuratively as a fairground hammer and bell, nurses were asked to name stressors or challenging situations and to 'rate' them according to their perceived level of emotional pressure. The top of the bell constituted a maximum score of 100, whilst the least pressure on the hammer constituted the zero score.

Taking all of the stressometers into account, the difficulties or positive challenges encountered did not correlate with what were consensually perceived to be the worst stressors. For example, caring for the dying and the resuscitation of a very sick patient were agreed to be the most feared aspects of nursing work. Making a drug administration error came a close third. In theory, therefore, these aspects of care could be expected to be the most stressful and emotionally laden. But when asked to rate different stressors these actually came quite low on the scale, perhaps because they weren't everyday occurrences. Dealing with death and bereavement therefore achieved an average score of 40, while everyday headaches, such as dealing with routine paperwork ,or managing the doctors' ward round accumulated a much heavier score of 80 and was rated as a constant stressor over an occasional one.

The conclusion reached by co-researchers was that the major stressors were not in fact major after all, as the perceived 'minor' stressors had a much more damaging cumulative effect on the mental workload of practitioners. Contrary to the primary researcher's expectations, there was in no sense any conceptualisation of an emotional 'reserve' for dealing with stressful events. Rather, each day seemed to be viewed or approached as a 'new' day. The thought of mentally piling up different stressors and then counting their effects was considered too dangerous or demoralising for staff. This "one day at a time" philosophy seemed to be integral to any sense of personal order, control and/or stability for individuals.

Some preceptors in the study were so taken with the notion of a '*barometer of emotional health*' that personal '*stressometers*' were encouraged as part of the learning support process, with preceptees being asked to define and reflect on their personal stressors as they experienced them in day to day activities. Their use seemed to offer a means of helping to establish some level of emotional control over the high demands made on them, and also gave their experienced colleagues an insight into those areas of care or management which might usefully be managed better.

Another major benefit which seemed to have been derived from the study was the opportunity preparing for preceptorship gave to trained staff to reflect on their own capabilities and practice. This was not all plain-sailing, however, as the discussion which follows here and in Chapter Seven will demonstrate.

The Support Paradox

Related to this problem of identifying stressors was the paradox created by preceptor support.

This was the discovery that those who proved to be the most approachable and expert at providing support carried a much heavier emotional load than their less accessible colleagues. Certain individuals were able to establish a better rapport with newcomers, appeared to be more sympathetic to their fears and aspirations, and were better able to convey this understanding in a way which attracted individuals to them and captured their attention. Such people were also ready to volunteer themselves and were prepared to become more emotionally involved with prospective preceptees, so that when the time came for ward managers to allocate a preceptor, certain names fell more easily into the metaphorical hat. This was a problem for everyone, not only because this placed an unfair burden on the individual concerned, it also allowed others within the team to delegate and abdicate responsibility for providing support in the hope that this person would leave them *"to get on with other things"*.

The effect of this was to polarise responsibility for support into the preceptor camp exclusively. This was especially hard for some preceptors, particularly where they were also assessors of practice, and therefore had responsibility for assessing the work of students as well as the trained staff. Whilst some preceptors initially thrived on 'the need to be needed', others soon found that other aspects of their work suffered, to the detriment of their own personal development and, occasionally (it was perceived) their prospects for promotion. This latter charge however, has, over time, been proved to be unfounded, in that a substantial number of preceptors in the present study acquired quicker than usual promotion to higher grades or other jobs, the reasons for which are open to some speculation.

Unit Preceptors have argued that Designated Preceptors grew in confidence and acquired the respect of other colleagues for being able to carry out their own work on top of the demands made on them as a preceptor/co-researcher.

Others have maintained that only the 'high-fliers' in an organisation would ever volunteer for preceptorship anyway, thus seeing and capitalising on the opportunity it provides for proving one's mettle. The primary researcher suspects the answer may lie somewhere between these two arguments, with some preceptors anticipating a career move, while others were genuinely able to reflect and make career decisions for themselves by virtue of the self-scrutiny offered to them by involvement in the study.

Some evidence for this exists in the small number who decided that nursing was not, after all, the career for them. Membership of a preceptor partnership (either as a preceptor or preceptee) was, however, for some the catalyst for other life decisions, such as coming to terms with their own sexuality, starting a family, leaving to take up a university course or other sea-change. Overall, the interpersonal learning process offered participants the chance to examine their personal feelings and priorities very carefully. Given the unreliability of exit interviews for establishing the real cause as to why employees leave the organisation, it was virtually impossible to establish which actions were the direct result of involvement in preceptorship, and those which might have occurred naturally anyway.

The support paradox, is, however, something which was firmly established in the minds of co-researchers, and as such it should inform future policy decisions.

The particular constraint this places on sustainable support policies has not been adequately described or articulated before, and some consideration will now be given as to the politics of skill rehearsal, and the particular problems the paradox raises for the large scale introduction and management of support across institutions and employers.

The Politics of Skill Rehearsal: Preceptors as Judge and Jury

Interviews with preceptor pairs and with individuals highlighted issues of peer support affecting the implementation of formal support in the workplace. From a nursing perspective, it was found that the relationship fared much better when formal assessment of performance was effectively removed from the support process. By keeping strictly to a supportive non-judgemental ethos, both parties found it much easier to admit to feelings of inadequacy, to share misgivings and fears, and to disclose important personal information which might have been considered prohibitive under conditions requiring a formal judgement of preceptee performance.

This decision was, however, a major departure from previous models of preceptorship, where some considered analysis of the preceptee's ability to meet set objectives was closer to the norm. Within a strictly peer relationship it was found that the problem with performance assessment was its denial to partners in the relationship of a true feeling of reciprocity. One health employer who did not take part in this study told the primary researcher that the purpose of the preceptorship support period of four months was to identify those who were competent from those who were not. Accordingly, the practice of that employer was to set particular behavioural and task objectives for the new appointee, on the basis that should they fail to meet preceptor evaluated requirements by the end of the four month 'support' period, their contracts would not be renewed.

At a meeting with senior UKCC officers in 1992 the present researcher had also been told categorically that preceptorship was not intended as a probationary period for the newly qualified, as this would suggest some broader concern with Project 2000 nurses being perceived as unable to meet the competencies required for qualified practice.

This would be considered political dynamite within nursing as it was the UKCC who had advocated the project 2000 reforms in the first instance. Thus, even though the statutory body responsible for professional standards was maintaining that all was well, this clearly did not prevent employers from interpreting the situation differently.

Any suggestion that contracts of employment should be affected by preceptorship was anathema to participants in the present study who did not relish taking on the role of "*judge and jury*", and who saw 'top-down' objectives as a potential "*stick to beat new nurses with*", as a coercive and restrictive practice which would severely limit the autonomy of nurses, and which would make any hope of a mutually satisfactory relationship between preceptor and preceptee unlikely.

From the employer's point of view, however, it could be argued that this defensive reaction to uncertainty over new nurse competence seemed to be a rational (if 'knee-jerk') response to concerns being expressed over the practical competence of emerging P2000 diplomate staff.

Even more interesting for co-researchers in the present study, however, was the development of a system of *peer review* through preceptorship, as not only did preceptors have the opportunity to 'shadow', guide and comment on the difficulties encountered by their preceptees, but they too found their practice under scrutiny in a process of self and peer evaluation and reflection on practice. In the interviews with preceptor pairs it was clear that this gave both partners the valuable opportunity to enter into and examine the rationales for each others actions and responses to situations, and to gain insight into different ways of meeting the demands made on them. Benner et al express this cogently when they observe that:

"Beginners can ride the coattails of the competent through expert nurses' practical experience and break the rules with this careful oversight. Experiential knowledge is best shared ad hoc and in relation to particular dilemmas while the learner is deeply involved in the patient care situation. Beginners learn from preceptors how to weigh and balance competing concerns and attend to the most important concerns in concrete experience with [the] many patients they encounter together"

(Benner, Tanner & Chesla, 1996:73)

In the present study both partners were surprised to acknowledge the provisional nature of many decisions made about practice and the general lack of self-confidence expressed by both partners. In addition, while mistakes or errors made by the preceptee could be dealt with using policy guidelines, a much more intractable problem emerged when the more experienced preceptor showed weaknesses or errors of judgement in day to day practice. No-one who was present at the beginning stages of this study had considered the possibility that the preceptors would be anything other than exemplary in their conduct or actions; so that, while early provision was made for the eventuality of any preceptee error, no guidelines were therefore in place for dealing with preceptors who fell below the standards expected of them.

The problems encountered by preceptor pairs were brought more fully to light when 1:1 interviews were conducted, and when personal disclosures were made by individuals as to the ways in which either party felt let down by the other. One preceptee, for example, felt that:

"The cosy relationship we had was OK until she dropped this terrible clanger and told the wrong person their relative had died. I was on the same shift and she [the preceptor] came over to me and started to cry and asked me what she should do now...I was taken aback...Here was this person I'm supposed to look up to and she's all over the place and dropping clangers like that...It made me wonder what my chances were when somebody that experienced could still get it wrong..."

Preceptors felt the need to set a good example:

"We're very like chalk and cheese. Sometimes I felt like the big, bad ogre always on his back for this or that. At one stage I was getting extremely upset at him for not pulling his weight. I was shouting and saying that OK, if he wanted to sink he could sink, but he wasn't going to do it on my ward. He'd been difficult and stroppy as a student and nobody'd tackled this problem head on. The school [of nursing] were aware of it and so were the senior staff, here, now it was left up to me to sort him out. When his timekeeping got really bad I withdrew my approval and he didn't like that. Then I felt bad - thinking who am I to boss him about like this? Still - he had to learn or he'd sink, wouldn't he?"

On the rare occasions where preceptors made an important error which threatened to have serious consequences for a patient, the issue of whether that person should continue as a preceptor was lost amidst procedural matters designed to protect the patient. Where preceptees actually witnessed the error, or challenged a preceptor's decision over care, real anguish was experienced at times over whether to try and gloss over difficulties, or whether to deal with the situation together. Ultimately, relationships either survived or perished, depending on the outcomes of the situation and the level of mutual emotional and psychological support felt in the relationship.

Where mutual trust was broken (for example, when a preceptor lied to a manager that he had been consulted by a preceptee before an action was taken), the relationship broke down completely, and considerable difficulties were experienced by preceptor co-ordinators in picking up the pieces of the relationship and dealing with the procedural aftermath. One preceptee caught the mood accurately here when she said that:

"[H]onesty is important in the preceptor relationship. Honesty can be hard sometimes, but you don't just want the preceptor to be nicey - nicey supportive or you won't learn from your mistakes..."

Benefits to Patients

A major benefit for patients of the preceptor support network was that of finding "two heads [to be] better than one" in resolving day to day problems in the workplace. Where previously a lone practitioner might have highlighted a problem, too little power or influence might lead to a failure to take restorative action. With the support of an experienced practitioner behind them, even inexperienced beginners had an advocate.

This led to substantial changes in practice in some working environments, not least in the conditions and practices affecting the lifting, handling and pre/post operative care of patients, patient communication, dealing with bereavements and the more humane transfer of patients from one department to another. The use of critical incident analysis to highlight particularly good, bad or even indifferent, examples of practice helped preceptor pairs to make provisional plans for possible future courses of action, encouraged them to make up the perceived gaps in their knowledge base, and to influence policy and practice at a tangible and influential level.

It was increasingly clear from discussions conducted in preceptor support meetings, however, that the successful conduct of preceptorship depended heavily on the 'troubleshooting' skills of the Unit preceptor. Designated ward (or area) Preceptors felt that they would be lost without being able to call on the Unit Preceptor for help and information on hospital or area policies. This may, in part, have been because Unit Preceptors were high profile experienced and much respected nurses in the organisation, and as such it was natural that less experienced nurses should turn to them for guidance when they encountered problems in the workplace.

What has not, and cannot yet, be evaluated, is the extent to which Unit Preceptors - as co-ordinators - were responsible for the relative smooth-running of the preceptorship network, as to grasp some measure of their influence a comparative study leaving out the Unit Preceptor contribution would have to be carried out.

The Costs of Caring

Preceptorship in nursing has already been declared an "inadequate and ambiguous response to the quality of pre-registration education, the role of the nurse tutor, the inadequacy of clinical teaching and rostered service, and the validity and utility of nursing theory" (Bowles, 1995:25-28).

Bowles argues that the principal effect of formal preceptorship is to shift the burden of responsibility and accountability from educationalists onto clinical staff and the organisations which employ them: thus, this may effectively divert much needed resources from patient care, and contribute to "a decline in educational standards, in particular with regard to the practical clinical skills among newly registered nurses" (ibid). The findings of this study would certainly concur with Bowles' assertion that too high a burden is being placed on clinical staff, and that the UKCC should urgently re-examine its understanding of competence, and reconsider the standards to be achieved by the newly qualified.

Unrealistic expectations on the part of staff at all grades and in a variety of specialisms may have much to do with the culture of negativity currently affecting qualified nurses, so that some considered reappraisal of the costs and benefits of challenging the ideal in nursing needs to be urgently realised. Farmer (1993) sums up the problem in just two paragraphs:

"These are difficult times for nurses. Caught up in a political climate of oppression, there is a prevailing sense of hopelessness which is intensified by the absence of effective leadership of the discipline. The tension created by the opposing values of the market philosophy and care and concern for humanity has intensified the self-destructive behaviour which has been a feature of nursing since it emerged in an organised form. In order to heal the self-inflicted wounds of the discipline, nurses need to understand how the current situation evolved and urgently to address the associated issues.....

We can all remember times of suffering in our professional lives. Sometimes the hurt is of a personal nature; more often we suffer because we have failed to respond to the needs of our patients and clients. Rationalising about associated factors such as scarcity of resources as a reason for our impotence seldom alters the sense of failure, or relieves the pain that is its product. Failure to act on behalf of patients or to support colleagues in a fight for justice is a failure to care, and to exercise the power that is inherent in caring"

(Farmer, 1993: 33)

The difficulty is that such an appeal to nurses not to abuse their power in caring for people places yet more onus on individuals to fight social injustice, and to reckon with the 'forces of darkness' which appear to undermine their stated advocacy of the vulnerable public. It is perhaps no coincidence that nurses lead the way for women who commit suicide. More than five percent of all suicides in the 10 years to 1992 were nurses, some 523 nurses are said to have killed themselves (Mullin, 1996:3).

In the pursuit of better conditions therefore it is important to maintain some sense of emotional balance when considering the pressures on individuals, so that the vagaries of the system do not become the sole responsibility of those charged with caring. The 'reductionist' approach to health care typified by market principles must force nurses, in Ellis' view to ask, "What cost caring?" (Ellis, 1992:210). However, it is also evident from the data trawled for this study, and from the concepts and constructs which informed it, that the meanings inferred and the problems faced are much greater than any simple value conflict with prevailing power structures in meeting health care demand.

Rather, they force a critical examination of nurses' own expectations of their conduct, and of the need to develop greater emotional literacy, so that instead of turning inwards to punish themselves for their supposed misdemeanours, nurses might connect with the wider world, to see that elsewhere people are experiencing a similarly 'damaged life' in the postmodern sense (Sloan, 1996).

By recognising the wider social influences at work nurses may thus be relieved of this sense of burden, of their paralysing fear of failure, emerging instead to explore and challenge the cultural assumptions underpinning their role learning which expect them to put their own emotional and physical needs last. Nurses are not the angels the popular media would profess them to be. They are human, and should be able to say so, from a position of influence in the caring work that they do.

Nurses will often feel bruised and confused when they enter the arena of public policy debate (Davies, 1995: 187), but that is no reason to withdraw from the arena. A revitalization of public life and a rethinking of the key institutions of social welfare is within their grasp and, if Davies is right, they may be able to help us move on from the "limited visions of reform" here in the UK which has characterised health care in recent years (ibid: 187).

Contemplating the Rubble: Emotions and the Research Process

Having negotiated the data mountain, in this final section of the chapter the researcher hopes to address the issue of the emotional involvement of co-researchers in the research process. These concern expectations surrounding the research process, and the estimated effects of the study on its participants and others affected by it.

Qualitative researchers are said to only gain control of their projects by first allowing themselves to lose it (Kleinman, Copp & Henderson, 1992:9). In popular research mythology, "the researcher becomes the hero who went on a dangerous journey and lived to tell us about it" (Kleinman & Copp, 1993:17). Emotions and research from a positivist point of view could be seen as a straightforward contradiction in terms.

The emotional involvement of researchers in their fieldwork receives scant and dismissive attention in the research literature with the notable exceptions generally being found in the feminist canon. For this particular researcher, and the scores of fieldworkers who entered into the study emotions represented two sides of a rather weathered coin. The first side concerned the emotions generated by the study of new role learning (an emotional subject, it appears in its own right), while the second represented the emotions which surfaced as a result of being involved in a collaborative research project where the stakeholders were the researchers themselves.

If the project failed, then we could all expect to take a share in the disappointment. If the project succeeded, then we could all anticipate taking some of the credit. Such is the basis on which an action research study of this nature is based.

When considering the rubble left after the substantial period of digging, drilling and sifting through the mass of data acquired, it is important to reflect on the emotional aftermath of the project, as undoubtedly there were both costs and benefits to be had from a lengthy, demanding and searching study. The emotional investment required of this study was high. In achieving its stated aims, an in-depth and sometimes emotionally painful investigation of the feelings and values about human nature and human interaction was necessary.

In examining critical incidents for example, the issues discussed ranged from witnessing patients bleeding to death, to allowing someone to die, to caring for the severely disabled and disturbed, to feeling in turn needed and rejected by the system which by all accounts and purposes exists to deliver humane care.

While some co-researchers devised ways of protecting themselves emotionally from the most searching questions, (for example, some participants chose to share a 'stock' or partially invented critical incident, rather than expose themselves to peer scrutiny and discussion over their actions), others were prepared to make much more startling disclosures. The primary researcher's increasing unease at such disclosures was alleviated by the empathy and gentleness of those listening: by the extraordinary experience of having nurses come together to discuss their most heartfelt concerns and recollections, and by their colleagues' careful and considered responses to what included information which - outside of the metaphorical four walls of the study - could be considered a legal and ethical minefield. What was clear is that practitioners found talking and sharing and empathising with each other a new and (for some) redefining experience.

The protection of researcher confidentiality is an assumed one in the literature, with few signposts being provided for the unwitting researcher delving into unknown, and largely uncharted, territory. There must have been times when co-researchers were shocked by disclosures, or occasions when revulsion against certain attitudes or stances must have challenged their abilities to be polite, to understand, to overcome personal prejudices. Yet for some nurses, the study clearly represented the first 'safe' opportunity they had had for sharing their anguish or misery over a certain issue.

The possibility of '*emotional contagion*' or '*postural echo*' where individuals feel compelled to share in others' anger, frustration, pleasure or distress must therefore have been, on reflection, an ever-present one (see Hatfield, Cacioppo & Rapson, 1994). However, given the negativity and derision expressed by co-researchers regarding the support of their colleagues, the reality remained that within the safe space of study they were still able to maintain a sense of mutual respect and candour about the 'reality shock' of nursing work without placing themselves in a morally difficult position.

This came as a genuine and life-affirming surprise to many participants, as is evident in the comments which were received on formal evaluations of the process. Whether this 'safe space' still exists, or whether anyone now regrets their disclosure remains a matter of open conjecture. The opportunity still exists for researchers to remain collaborative, and to maintain supportive collegiality. Whether they will is ultimately their choice and their decision. Expectations of the research process were also extremely high. For the primary researcher this caused particular difficulties in that the study was at times interpreted as promising much more than could realistically be attained.

Coming as it did in the wake of major organisational reforms, the opportunity to shape and manage transitions through the project was occasionally interpreted as a means for managing structural change more effectively. Thus staff who anticipated a positive career move and who were then offered only redundancy perhaps suffered more emotionally because of the study's involvement than they might have done had it never existed. Although this remains on the researcher's conscience, in reality there were forces at stake outwith the study which at the beginning were perhaps too dimly realised by all concerned. At the very least then, the study can be said to have acquired culturally valid answers to the research questions posed.

Kleinman and Copp are critical of the belief that talking to others about problems or uncertainties in research makes us vulnerable to charges of incompetence or weakness. They urge researchers to instead acknowledge their "*interdependence*" with the outside world. By claiming the strengths [and presumably] weaknesses of our methods and the uniqueness of our identity, we will in the end make better fieldworkers. It is they say possible to recognize the constructed nature of our work without "having it muddy our critical eye". Emotion is in the end integral to all human experience:

"We can give up the individualist model and instead create interdisciplinary networks and informal groups that encourage us to give and receive intellectual and emotional support. In our experience, having co-operative contexts in which to think, talk and write makes us work better and feel better".
(Kleinman & Copp, 1993:56/57).

From a Socratic perspective then, it could be, and should be, '*the right way to live*'.

Preceptorship and Policy Evaluation

Having examined the emotional nature of the transition from inexperienced to experienced nurse, it has also been helpful to collectively examine the intentions and rationale of preceptorship policy in practice, and to come to some tentative conclusions about career transitions and what they signify for practitioners in terms of the development of practice and *shared constructions* of what it means to practice as a qualified nurse.

Career Transition as a Meaningful Construct

The notion of 'career transition' has been a helpful and enduring construct for use in the study.

Although debate was invited on the usefulness and precision of the term 'career transition' no alternative conceptions emerged or appeared to describe so accurately the idea of moving from one perceived status to another. Support for the concept of 'career', or, more generically, 'learning transition' was universal amongst co-researchers by the end of this study.

The notion of transition appeared to be viewed much more positively than 'change', as it was generally accepted that life experience constitutes a series of transitions which may, or may not, be marked by specific age related events. The conceptions of adult learning engendered by the study of 'life stages' or strictly linear developmental models of life experience which have informed the established psychology literature (e.g. Piaget 1952, Eriksen, 1973, Levinson, 1978) may, therefore, in these more turbulent times, be inadequate to the task of fully describing the texture, colour and shape of human learning transitions.

Learning as 'Transformation'

Theories which emphasise the restructuring of meaning or transformation of perspective in the adult attempt to capture what is unique about adult learning (Merriam, 1987:196). Transformational learning, in adult education 'speak', is said to *shape* people, so that they are different afterwards in ways both they and others can recognise (Clark, 1993:47). Approaching learning from a developmental perspective, however, is limited in its outlook, in that it assumes a predisposition in the learner to move from one developmental stage to the next. The meanings associated with new role learning in this study would appear to challenge this important assumption, as transitions encountered were not always considered to be progressive or developmental in nature.

The humanistically derived 'personal growth' theories exemplified by Carl Rogers, for example, (e.g. Rogers, 1980) would appear to find stony ground in an occupational culture which is heavily and philosophically constrained by material and economic factors, by competitiveness and by the drive for mechanistic efficiency characteristic of contemporary public as well as private sector organisations.

The characteristics of adult learners' (CAL) model proposed by Cross 1981 (for example) may be too limited by its attempts at trying to elicit and classify the particular characteristics which distinguish adult approaches to learning over those of the child. This study has found that, emotionally, adults experience the same fears about learning in adulthood as they did as a child. Negative expectations of workplace learning concerned fears of personal humiliation, fear of being found to be inarticulate, or lacking in some essential knowledge.

Fear of failure to achieve both their own and their peers' expectations of their performance was considered more emotionally damaging than reneging on responsibilities to, or being found inadequate by, employers and managers. Positive expectations appeared to be met only rarely, suggesting that, in nursing work at least, a culture of negativity has gained precedence over the rhetoric of lifelong or continuing learning. Fear of "failing to make the grade" may also suggest that the strategy of professionalisation adopted by the nursing leadership, combined with the market surge in the provision and proliferation of accredited learning opportunities, points to the emergence of a 'credentialling crisis' which is in direct political opposition to current governmental strategies towards multi-skilling and the dilution of skill mix by minimally or unqualified workers within the health care marketplace here in the UK.

To continue to stress personal development as separate and distinct from occupational or contextual culture is therefore to deny the lived experience of human beings.

In nursing work it appears to be especially cruel, as the personal demands on carers physically, emotionally and intellectually are, it would appear, relentless and unabating, affecting not only the newly qualified, but experienced practitioners as well.

The traditional emphasis on formal learning appears to have focused attention away from the learning to be acquired from practice, hence the practice (as distinct from) theory has been effectively devalued. This has important implications for the recruitment and retention of staff who may be employed to care, and some consideration and further applied research into this issue would seem to be advisable.

The career transitions described by co-researchers were many and varied, and reflected the changing work patterns and practices of public sector employers.

One particular aspect of transition which appears to have gained favour is that of reducing work hours to accommodate domestic commitments. Senior staff in particular were concerned to "level off" their emotional and intellectual involvement with work, fearing the extra responsibility and demands of nursing work at ward manager level.

This may have profound implications for the career structure within nursing, but, as importantly, it may also suggest that the professionalisation of nursing is at odds with the practical and interpersonal nature of nursing work. Co-researchers appeared to become less emotionally attuned to a nursing ethos with the adoption of management related responsibilities. An emotional distance therefore begins to be felt between those perceived as 'real' nurses, and those adopting a business orientation to nursing work.

This may, or may not, constitute a divide and rule strategy for the effective control of the nursing workforce. What it does clearly represent is a dissonance of values between those working at the 'human' end of practice, and those attempting to fulfil both nursing and managerial obligations.

What this study has found, and what future theories must take into account, is that human beings do not always succeed in making the psychological transitions required of them within an occupational or cultural context. Adult learners are not placed strategically on some metaphorical factory conveyor belt, ready to be transformed from one state to another. Emotional involvement would appear to be a key factor in helping individuals to make successful and sustainable life transitions, and in order to understand the future, it is perhaps necessary to better appreciate and come to terms with the emotional past.

Values clarification and the emotional literacy brought about by skilled evocation of and reflection on critical incidents, feelings or happenings, can be cathartic in the psychoanalytic sense. They also have the potential to be life enhancing from the point of view of shared human frailties, attentiveness and openness to new world views, and by suggesting alternative ways of thinking about the world and what passes for human existence within it. People have subtle ways of subverting the cultures' overt pressures to conform, but at times, it would seem, this can also deny them their sense of emotional well-being. In outwardly conforming (and inwardly suffering) some people can be put at severe emotional risk, with the consequent stressors impacting not only on their physical and psychological health, but on the health of organisations, and the quality of the human relationships, which taken together form the whole.

Criteria for Providing Effective Preceptorship

In striving towards a practice based theory of preceptorship, four criteria appear to be cardinal in managing effective and personally sustaining learning transitions.

The first is that formal support mechanisms require the strategic and committed support of those managing organisations, whether in the workplace or in the delivery of educational opportunity.

The second is that values clarification between the experienced and the inexperienced is a necessary and valuable prerequisite to acquiring the skills and emotional literacy required to negotiate the transition from novice to confident practitioner.

The third is that expectations of the beginning practitioner must be made explicit, or the will to succeed may be compromised by confusion and 'interpersonal moral distress'. Realistic but positively constructed appraisal of what is expected of the newcomer is preferable to a rosy interpretation which then leaves the individual feeling inadequate and 'out of step' with their new colleagues.

The fourth is that attempts to create a culturally permissible 'safe space' which allows for the testing and formulation of self-concept in relation to new work has potentially significant advantages for the employer as well as the employee. This enables expectations of the new employee to be properly and meaningfully articulated, resulting in fewer misapprehensions and errors in decision-making, both personally and in relation to the achievement of organisational goals. The greater the level of clarification, the less dissatisfaction and dissonance is expressed.

Co-researchers concluded that this places individuals in a better position to assess their suitability and aptitude for working or learning in a particular context, while at the same time allowing themselves the emotional leeway to recognise alternative futures and perspectives. Those who choose to stay within an organization which fosters this ethos are therefore likely to acquire greater employee commitment and loyalty than those who work in organisations which strive for 'compliance' using more traditional didactic and/or autocratic measures.

It is also important to deal with the distinctions between what has recently come to be described as *clinical supervision* in health care practice, and the part played by preceptorship in helping to appropriately supervise employees in the workplace. Preceptorship enhances opportunities for reflecting in and on action in clinical practice, and as such contributes to a positive ethos for learning and for the development of ethical practice. What it cannot do, using the model employed here, is provide comprehensive supervision as it has come to be described in the contemporary literature (e.g. Butterworth & Faugier, 1992, Butterworth 1997) except when used as part of a broad, shared strategy of structured organisational, managerial and educational support provision as described by Nicklin in his very recently published 'practice centred' model of clinical supervision (Nicklin, 1997). Despite the longstanding preoccupation with clinical supervision in the UK literature, and protracted debates concerning the terminology used to define support concepts, co-researchers in this study concluded that too much attention has been paid to the semantics of support provision in the past. It is crystal clear from the evidence provided by co-researchers that while the proverbial Nero fiddles, Rome continues to burn. The nurses involved in this study did not particularly care about the label or name given to their formal supporters in the workplace. They cared much more about whether the expectations of support were realistic, attainable and sustainable across the workplace and over time.

As one Unit Preceptor has described it: "*What all nurses, not just new nurses need in times of emotional strain is nothing more, and nothing less, than a 'friend on the ward'.*"

Clinical support and supervision are not synonymous, as has often been assumed in the nursing support literature; as the former, to be successful, requires an ethos of mutuality and mutual vulnerability which is not permissible within a formal supervisory framework. The uncritical acceptance of supervisory support models within nursing, given our findings, runs the very real risk of leading to the practice of "defensive nursing" as the antithesis of the autonomous practitioner. When nurses are vulnerable and frightened, the ethos of formal supervision is likely to inhibit rather than foster new learning. It is therefore important to continue to clarify and communicate nursing values within the prevailing political climate, and to exercise the necessary courage needed to assertively question the cultural validity of new concepts and directives issued to nurses and other health care practitioners from "above".

The old lawyer's adage of *caveat emptor* is a useful one for practitioners to adopt, and reflects the healthy scepticism so necessary to critical thinking in adulthood (see Brookfield, 1987). If nursing is to truly come of age within this brave new world of 21st century health care in the developed world, then it may have to face some uncomfortable home 'truths' about the cultural values it espouses and then (according to accounts taken from those involved in this study) fails to deliver to a significant number of its practitioners.

Preceptorship as it has evolved in this study may therefore be summarised in relation to those *problems, constraints* and *opportunities* it represents to nurses and other health workers.

Problems

*Role boundaries are an ineffective way of attempting to describe the expectations of a new employee. Co-researchers in the present study found that preceptors felt that they did not have sufficient confidence to be able to delineate these 'boundaries' effectively. The action research approach allowed for the discussion and clarification of these issues over time, but it was recognised that Practitioners elsewhere need to be aware of this difficulty when planning the implementation of formal support networks so as not to place too much emphasis on arbitrary conceptions of 'role'.

*Overload on Preceptors required careful monitoring. The information and education of colleagues outside of the support relationship (and particularly service managers) appeared to be an important prerequisite to maintaining the required stamina for success.

*Clarification of what was expected was much easier for all concerned once the principles and philosophy of transitional learning support i.e. preceptorship were agreed between the two parties. The absence of any coherent principles in an ad hoc or less structured arrangement may therefore leave individuals vulnerable to misunderstandings or confusion.

*Preceptor dependency or transference was an occasional problem, and this was resolved amicably through Unit Preceptor intervention. The absence or lack of a third party to oversee the preceptorship process might therefore be problematic in areas operating on the basis of partnerships alone.

*Researcher dependency was also problematic at times: care is needed in future research initiatives to ensure that false expectations of the research process don't arise. Levels of emotional investment, contagion and labour were high. Career transitions can include redundancy and unpalatable redeployment.

*Preceptor error is always a realistic possibility. Staff need to be aware of the impact of active and passive role modelling at work. Contingency policies need to be worked out in advance, so that if problems occur each partner has appropriate guidance to lead them.

*Preceptor reward systems need to be systematically re-examined in the light of the 'credentialling crisis' affecting nurses. Preceptorship skills should be recognised via the formal accreditation of workbased learning, so that preceptors can build on their learning whilst actively caring for their patients and colleagues. The downside of the increased skill base of the preceptor has in this study been the constant movement of staff brought about by increased preceptor promotion prospects. This is helpful to the preceptor, but can be disrupting to the work environment and disorienting for staff. Unit Preceptors are needed to deal with the gap left behind!

Constraints

* Preceptorship is undoubtedly resource intensive and requires commitment from staff on a grand scale at all levels in the service. Minimal preparation time for preceptors is roughly equivalent to 200 service hours per year, per designated preceptor, in addition to the costs of staff cover to make up for time given over to working with preceptees and administering formal learning documentation.

* The absence of "warm bodies" is a problem, in that not enough experienced, qualified, willing non-encumbered staff are around to assume the mantle of preceptors, largely due to overload on staff already acting as formal assessors of clinical practice.

* Senior staff were generally found to be less empathetic to the needs of the new practitioner, and may need to have their awareness of this critical issue raised. The optimum level of experience required to be a successful preceptor appears to be 2-3 years since qualification in the relevant area of practice.

* Preceptor facilitation is a slow process. There is a need to disseminate the findings of this study quickly and convincingly in order to secure appropriate levels of funding and high level strategic backing for clinical support initiatives. A clear differentiation between clinical support and supervision is essential if nurses' *emotional support needs* are to be recognised.

*Political problems exist regarding 'fashions' in learning support concepts. This study stressed the important distinction between clinical and career socialisation. However, the impetus for clinical supervision following on from the conviction of former nurse and child murderer, Beverley Allitt, has polarized the debate towards restrictive role supervision rather than role development (i.e. Clothier Inquiry, 1994, see also RCN, 1994b, Naish, 1997). This study concludes that a poor record of research and policy dissemination has hindered the meaningful evaluation of support constructs, leading to some disillusionment and cynicism regarding the feasibility and effectiveness of support, particularly in areas where there is a high turnover of patients (and thus less time available for support provision). The statutory bodies are asked to take note!

*Fragmentation of the service and an apparent weakening of the contribution of professional advisers at what were previously high level appointments in nursing appears to have effectively disenfranchised many previously powerful and therefore influential practitioners. Without effective high level leadership nurses' influence on crucial policy decisions is lacking, and may contribute to the feeling of disenchantment with nursing as a career.

Opportunities

A number of opportunities were also identified by the present study. These included:

*Possibilities for the creation of a new taxonomy of transitional learning support i.e. the recognition and development of a new language for dealing with interpersonal and emotional aspects of learning such as those raised by preceptor support.

*Increased advocacy of beginning practitioners was the outcome for many - with the need to act on problems becoming an obligation to both partners in the support relationship. Practitioners found it much easier to act on inconsistencies or poor practice by approaching the problem together rather than as a lone voice.

*Structural and organisational problems affecting the daily work environment, such as poor management practices, inadequate or inappropriate skill mix, weak leadership and strained interpersonal relationships became more apparent as teams were exposed to the scrutiny of the action research 'gaze'. Preceptorship questions the status quo, and not all practitioners were aware of the potential depth and breadth of the preceptor relationship with regard to both clinical policies and procedures as they were enacted. Some changes to established practice were immediate and stood the test of time. Others happened only gradually and some depended on the tenacity of individuals for their survival as substantive changes to policy and practice within their institutions.

*The relationship between stress and sickness/absenteeism were made clearer via the support process, leading to proactive measures and greater shared responsibility for mediating work overload. One co-researcher followed this up as part of her own professional development activities with a view to establishing any identifiable 'warning signals' of preceptee distress which might be used in future preceptorship practice.

*Improved practice - i.e. qualitative changes and modifications to care were made possible via collaborative learning, leading to shared, rather than defensive thinking and problem-solving. This led to greater appreciation and recognition of the strains incumbent on both partners, and to a greater feeling of collegiality and friendship between colleagues in some clinical areas.

*Greater opportunities for 'role' modelling were identified. By discussing and defining 'best practice' locally in relation to learning support, and by systematic and thorough local dissemination of supportive behaviours it was possible to reduce the duplication of effort put into teaching aspects of care and to break expectations down more easily into their constituent parts. Hence, an appreciation of what is involved in adult learning - and its emotional impact - is now better understood from the perspective of beginning practitioners in nursing.

*The audit of transitional learning support was made possible by setting criteria for good practice in preceptorship. Criteria for assessing the suitability of potential preceptors was also clarified. This information constituted the model of preceptorship which evolved through the collaborative efforts of all co-researchers in this study, and as such it has been formally audited in clinical practice with longterm positive outcomes reported for both education and practice (NHS local Audit Report, 1997).

The Future of Preceptorship

It would seem that people in organisations (and out of them) are more than empty raincoats rushing from one consultation to the next (Handy, 1994). Opportunities to extend preceptorship to other areas of practice and occupational territories therefore remains a vital consideration for policymakers. Within nursing itself there have been recent calls to make preceptor support a statutory requirement for all health care employers (Maben & Macleod-Clark, 1997).

Career transitions are commonplace, as the literature amply testifies (e.g. Knox, 1995, Zapf, 1991, Kachoyeanos-Selder, 1993). The potential to identify the transitional learning needs of others in the public sector occupations is an obvious first port of call. Police, ambulance and fire service personnel, social workers, counsellors and probation workers, teachers, academics, student counsellors, doctors, and staff involved in occupational, speech and physiotherapy services all stand to benefit from a closer examination of what it means to practice their specialisms, and how it feels to be on the receiving end of some of the treatment or care decisions which impact on the life chances of their patients, students and clients.

From the experiences discussed via the present study, however, we must take care to see that the concept of *career* is not taken too literally, as this may otherwise exclude people from participating in the kind of support relationships referred to. The immediate corollary to this is the need for industry and commercial sectors to take on board the support message. The limitations of the classical mentorship model of career socialisation may be addressed through closer attention being paid to the emotional elements of transitional learning support. Not all people perceive success in the same way.

The clarification of values inherent in an occupational culture may well help individuals to increase their motivation and sense of belonging at work, or in the mutual sharing of different worldviews within a social situation. Hence, while it is not suggested that the findings of this study are generalisable to any particular population, generalisation to the theory itself may indeed be possible across a broad spectrum of occupations and life experiences.

We perhaps do a disservice to learners when we allow them to imagine that there is such a thing as order in the world, and that someone, somewhere will take responsibility for making it happen. The provisional nature of human experience, and the emotional crisis inflicted by this dishonesty is perhaps something which requires emotional courage to accept. Whatever our personal feelings about our stake in the future, learners have a right to relate and deal with the uncertainties and insecurities of the past. Our experience of preceptorship would suggest that the opportunities for making this happen may be greater than we have previously realised.

Reflecting on Process: Theory Development and Action Research

This final chapter is an attempt to engage in what Usher *et al* describe as 'metareflection', which has been interpreted as the ability to reflect on one's own reflective processes as a researcher and integral part of the research process (Usher, Bryant & Johnston, 1996:149). As such it will describe the ways in which theory concerning preceptorship was developed through the action research study; examine the role of reflection in theorising, (with particular reference to the experiences of both primary and co-researchers); discuss the link between theory and method in the study and, finally, assess the value of action research as a vehicle for reflection and learning.

The Development of Preceptorship Theory

The aim of any action research project is to "bring about practical improvements, innovation, change or development of social practices, and the practitioners' better understanding of their practice". As such it is not hierarchical and is characterised by open and symmetrical communication (Zuber-Skerrit, 1996:83). The 'raw data' of the present study was drawn from wide range of primary and secondary sources such as learning contracts and support records, focus groups, reflective diaries and minutes of preceptor planning and support meetings (listed in chapter three, p.103). Data was thus 'produced' as a direct result of policy implementation, so that evaluation of the policy then followed in tandem with the generation of 'micro-theory' i.e. theories put forward by co-researchers for problem solving and the better understanding of the transitional learning support process in practice.

Rolfe (1996) has claimed that 'reflection-on-action' can be refined into a model of reflective research whereby the nurse generates personal knowledge and informal micro-theory through reflection on his/her own day to day practice. However, in order to justify clinical or educational decisions made on the basis of reflection-on-action, it is necessary to be able to produce written evidence of a systematic process of knowledge and theory generation or the results may not be considered legitimate (Rolfe, 1996:62).

'Macro-theory' is then the product of the description, analysis and synthesis of the literature and micro-theory as interpreted by the primary researcher, whose task in this case was to develop the outcomes of micro theory into a communicable and authentic framework which might help others to develop preceptorship further. As co-researchers discussed, modified, and developed preceptorship the initial model proposed by the primary researcher (p.109) evolved gradually into a much more pragmatic tool for developing reflective skills in the workplace by proposing solutions to the minutiae of problems experienced, while at the same time recording data which could be used to draw out underlying assumptions and practices which were dominant to the discourse of beginning practice.

Macro-theory is thus the primary researcher's attempt to explain the phenomenon of preceptorship (i.e. transitional learning support) in such a way as to reflect the interpersonal, personal and and cultural/social aspects of the phenomenon through (in this case) the interpretive lenses of social constructionism and human ecology.

Such a synthesis therefore aimed to provide a framework for understanding a) the concept of preceptorship; and b) a description of the constituent elements or principles of good practice in preceptorship as evaluated by all those participating in the action research project. The criteria for effective preceptorship listed on p. 237 therefore constitute the practice based theory of preceptorship as it has evolved from this study.

No rigid definitions of preceptorship were accepted or offered by co-researchers (although this was what was sought initially in response to earlier confusion over concepts), but rather the generic descriptions of preceptorship as "transitional learning support", and "transitional learning support partnerships" were preferred for their flexibility. Thus, instead of being narrowly defined, preceptorship came to be seen as applicable to any worker in the organisation at any level of seniority. The support framework which evolved through the project (see Fig.1 below) seemed to offer the necessary 'concept stability' with the distinctions between preceptorship and classical 'mentorship' being made clearer than before.

Fig.1

The Clinical Support Framework

<u>Pre-registration Preceptorship</u>	<u>Post-registration preceptorship</u>	<u>Mentorship</u>
<i>Time limited 'clinical socialisation' offered to nursing students</i>	<i>Time limited 'clinical socialisation' offered to newly qualified, returners and those transferring to new area of practice or responsibilities or undertaking post-registration study</i>	<i>Informal 'career socialisation' No time limit</i>

Having produced an account of the study, however, it was not sufficient for the researcher to publish it and consider the process complete. The validity of the provisional findings continue to be tested through the cyclical process of action research with new preceptor partnerships being introduced on a regular basis by employers involved in both this study and in other initiatives. Action research is therefore not only about developing one's own 'praxis', but also about critiquing and changing the world (Jennings, 1995:81).

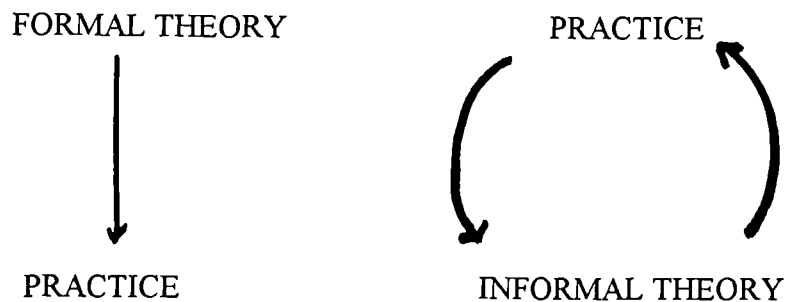
As Jennings has illustrated, the value of post-structuralist approaches to research is to expose the dominant forms of discourse "which silence non-dominant voices through power relations. By dictating the terms of the discourse one is able to dictate the relations of power" (ibid:83). Narratives listened to and heard in this study have, as Jennings suggests, helped to communicate meanings, project a (previously unheard) voice, provide multiple perspectives of the same phenomenon, and most importantly of all, enabled us to provide for future possibilities by recognising and 'knowing our world' through a particular discourse which was in turn open to deconstruction.

Deconstructionism (via reflection) enabled researchers to effectively "disrupt theory,....opening up conflict for tentative reconstruction" (Jennings, 1995:83). In this way we recognised ourselves as bound by our own constructions of reflection and therefore less likely to become prisoners of our own narrowly defined perspectives (ibid:78).

The synthesis of micro-theory to produce macro-theory can therefore be justified on the grounds that it was produced in the real rather than 'ideal world' world of practice, and is therefore entitled to acknowledge its "embeddedness" in its social context.

It also has potential for reducing the perceived 'theory-practice' gap between the so-called *grand theories* of nursing or education which draw on conceptions of the ideal world, rather than that which is tangible and accessible to practitioners (Tolley, 1995). This requires an examination, however, of the relationship between what Rolfe has described as *informal theory* and practice [which accurately describes the theory generated by action research in the primary researcher's opinion] and the rather different one which exists between *formal scientific theory* and practice (see Fig.2) below:

Figure 2



Informal theory and practice are mutually dependent and follow a circular process, with practice generating theory, theory modifying practice, which generates new theory and so on (Rolfe, 1996:27). Preceptorship theory as it has been accounted for in this study is therefore a good example of what Rolfe has described as a "new paradigm for nursing" (Rolfe, 1996:27), and as a legitimate 'practice theory' which McKenna (1997) has broadly defined as: "[A]ny theory which grows out of clinical practices, experiences and activities", with reflection being viewed as the preferred method for generating such theory (McKenna, 1997:118).

The Role of Reflection in Theorising

Although this has been touched on in earlier chapters it may be helpful here to make this process explicit. One of the dominant discourses revealed by this study was that of domination itself, i.e. with co-researchers viewing themselves as victims of more powerful forces, which were variously described as "*the health care system*", "*doctors*" or "*managers who don't understand*" (see Chapter 6 for examples).

As Jarvis (1995) has observed, concern with issues of human relationships in teaching and learning has not constituted a major factor in the preparation of educators of adults. Jarvis asserts that "Persons develop by having a greater variety of experiences and richer interaction with others", concluding therefore that this must be "the fundamental aim of education" (Jarvis, 1995:34). In a similar vein, Jones and Hendry claim that research must reveal the interdependent contexts that encourage and produce learning, so that there is room for "housing the human spirit" in any organization which wants to help their employees learn and develop (Jones & Hendry, 1994:159).

Brykczynska has pointed to the culture of negativity in nursing which she believes prevents nurses from making progress in their discipline: "A discouraged, pessimistic profession, full of disheartened practitioners, can neither provide innovation in the art of nursing nor meaningfully contribute to an improvement in health care 'civilisation'" (Brykczynska, 1995:22). Drawing on the work of Schweitzer she sees the challenge of the future in helping nurses to break through their existential insecurity and feelings of distress:

"The question [...] is, how can we break through the potential for negativity inherent in the social system and start producing wise nurses who can be seen to care and seen to be creatively active, knowledgeable and moral agents of society?"

(Brykczynska, 1995:24)

The processes of reflection undertaken as part of the focus group/experiential workshop methodology helped to articulate the moral basis for particular rituals and practices in the initiation of new practitioners to the workplace, and created, through the use of Socratic refutation, new vocabularies and positions which *might help others in the same* predicament to act in a more humane and moral way, rather than simply recycling institutionalised and damaging rituals of humiliation as a way of initiating newcomers to the practice situation.

Revelations concerning the (perhaps unintentional) "disabling" strategies enacted by experienced staff in the integration - or otherwise- of new practitioners were thought provoking and quite profound for some co-researchers and in particular for the most senior and experienced of them. This led to a deep and quite painful examination of the moral conduct of practitioners through a deconstruction of practices and behaviours towards new nurses. In attempting to reconstruct the experience offered to newcomers through constructive use of reflection-on-action (a discussion regarding their own recollections of those factors which had helped or hindered their own work entry), co-researchers found themselves "imagining" alternative forms of action and discourse. Their own taken-for-granted assumptions (e.g. "*these young ones think they know it all*", "*they need to learn what it's really like*") were countered not only by the reports of others' experiences, but through a detailed examination of their own journey from student to experienced practitioner.

The 'momentary power' enjoyed by practitioners in the relatively secure position of being in and "*knowing the job*", was exposed as a reproduction of other coercive forces at work. As nurses who were already 'socialised' they had begun to repeat a pattern of behaviour learned from colleagues in neighbouring disciplines and groups, notably that of medicine which is thought to be conservative as well as hierarchical and resistant to change (Mackay, 1989). Reflection-on- action therefore raised important and potentially life-changing questions about the morality and legitimacy of such practices and as to whether it constituted "the right way to live" in the workplace. Were nurses prepared to give up that 'momentary power' for something of greater value, such as a feeling of mutuality and collegiality among colleagues? Or were the rituals too ingrained and therefore resistant to change from the 'inside'?

Co-researchers may be convinced as to the corrective action required, but how might they then change practice for the better, given that they perceived colleagues who had not been directly involved in the action research study as a "*sceptical public*" likely to scoff at or reject change which was deliberately non-positivist and therefore inherently "*non-scientific*"?

One way of conveying this 'change of heart' was for the collective group of Designated and Unit Preceptors in a given unit or hospital to devise what was called their "philosophy of preceptor support". This amounted to a kind of mission statement as to the nature of support which the group, after lengthy discussion and debate, considered to be closest to their new 'worldview' of nursing as a positive, supportive and caring entity; in stark contrast to the demoralising, "*dog eats dog*" ethos of socialisation processes which they had experienced in the past.

Reflection-in-action and reflection-on-action were used by co-researchers to see whether the new philosophies espoused by them were realistic and attainable in practice, and if not, to consider whether they represented an 'ideal' to which they should, nevertheless, continue to aspire in the enactment of transitional learning support. An example of a philosophy devised by practitioners and used for this purpose is provided in the Appendix, p.303. It is argued here, then, that the study was able to go beyond the parameters of traditional research by increasing (or at least raising awareness of) participants sense of moral agency and ethical practice.

By engaging in critical incident analysis, co-researchers also promoted the principles of reflection. The generic strategy used was slightly adapted from that offered by Palmer, Burns and Bulman (1994), (Fig.3) but this was not intended to be prescriptive, and co-researchers were encouraged to critically analyse and expand on reflection concepts and ideas for themselves.

Figure 3 Reflection Strategies

What was my role in this situation?

Did I feel comfortable or uncomfortable and why?

What actions did I take? How did I and others act? Was it appropriate? How could I have improved the situation for myself, the patient, significant others?

What can I change in future?

Do I feel as if I've learned anything new about myself?

Has it changed my way of thinking in any way?

What knowledge, from theory, practice and research can I apply to this situation?*

What broader issues, e.g. ethical, political or social, arise from this situation?

(* adapted to include 'practice' here as a legitimate source on which to draw)

Webb (1995) counsels against the temptation to become formulaic or simplistic about reflection-on-action. Describing it as the "endangered species" of reflective practice, he has strong words for those he calls "the codifiers of action research", arguing that reflection is "a part of our being and diagrams of spirals, boxes and arrows do it little justice" (Webb, 1995:77).

However, in defence of action research it is important to acknowledge McNiff's observation that although the literature of action research and other person-centred forms of enquiry are rich in recommendations for self-reflection, "there is little corresponding evidence to show in action the processes of self-reflection advocated" (McNiff, 1995:86).

Wilson-Barnett (1996:306) has suggested that "illuminative action research" is perhaps the only method which will satisfy the needs of participants within a research project, although it should perhaps be remembered that action research does carry the danger of making complex processes seem more straightforward, or at least that is how it seemed at times to researchers involved in the present study. Reflection does require a certain maturity of outlook, and a willingness to be honest and critically sceptical of ideas. As Burrows (1995) has declared:

"Explicating practice knowledge is critical to learning....If qualified nurses use reflective thinking, they will not only self-evaluate, but also affirm the value of practice and knowledge-in-action to the profession"
(Burrows, 1995:347)

Articulating the Link between Theory and Method

In social research people provide the most obvious link between theory and method. While traditional research is primarily concerned with representing the interests of sponsors, action research is more political because it is in the public domain (Doyle, 1996). Clearly, neither the theory of preceptorship nor the value of transitional learning support would be worth anything if it were not for those involved in its creation.

Theory analysis has been described as "a systematic process of examining if the theory is valid in its composition and function" (McKenna, 1997:222). Every participant in the action research process is therefore a theorist in her/his own right. Ownership of the research is thus negotiated through the interpretation of competing perspectives. There is necessarily a distance between the primary researcher's analysis and that of others (Hawkins, 1996:105) which has to be accepted and acknowledged by readers or 'consumers' of the research outcomes.

The primary researcher could also be said to be in a privileged (and problematic!) position, of attempting to act as a bridge or channel of communication between the perceived ivory tower of academia and the equally hallowed ground of clinical practice. Thus the primary researcher is not able to *lead* the research process but rather has to *oversee* it. Without the tacit support of participants the link between theory and method is liable to break down. If participant unease goes unnoticed or even ignored, the validity of the research is likely to be called into question. In producing a reflective account, then, it has been necessary to address the potential conflicts that such interdependent relationships can produce.

In an effort to conduct the entire study in a Socratic manner, one of the tactics employed to articulate, analyse and manage the relationship between the primary researcher and her 'significant others' in the research process was the construct of a *psychological contract* (as discussed earlier in the literature review) which was used to try and clarify mutual expectations of the research process as the study developed.

The psychological contract entered into was multi-layered, sometimes formal and occasionally informal in character. Again the question of "What is the right way to live?" was used to reflect on and question the nature and moral validity of the relationship between the primary researcher and others. In this way an informal 'contract' of mutual expectation could be said to have existed between the primary researcher and co-researchers (as the immediate research community); the primary researcher and fellow research students (as her peers and broader research community); with sponsors (hospitals, clinics, settings used in the field); her research supervisor and teachers/lecturers at the university, and with interested agencies who provided logistical and financial support and information (e.g. regional health authority, library staff, professional organisations, colleagues in the nursing media and officials representing the statutory bodies for nursing, midwifery and health visiting).

This helped to place stakeholders in context, and to establish who the beneficiaries of the research outcomes were likely to be. It also helped to highlight those areas of potential conflict and contention in bringing the research to fruition. For example, at the time the study began, little active concern was felt for the future of recruitment and retention in nursing.

Although responses to recent educational reforms were mixed, practitioners looked forward with optimism to achieving the professional autonomy which Project 2000 seemed to promise (Kendrick & Simpson, 1992).

In 1997, however, real concern is now being expressed as to an imminent recruitment and retention crisis in the UK, with only 3.61% of nurses now under 25 in the nursing population, and a dramatic fall in the number of new practitioners registering for practice from 37,668 in 1986/7 (as Project 2000 was introduced) to 28,404 in 1996/7. A 30% dip in the number of applicants to nursing courses and the imminent retirement of a large proportion of the workforce is also at the heart of new concerns about finding effective ways to recruit and retain nurses, midwives and health visitors here in the UK (Nursing Standard *News*, 1997, November 19, Times Higher Educational Supplement, 1997, November 21).

While the implicit contract between the primary researcher and co-researchers was improved understanding and practices concerning entry to nursing in exchange for "access" to the field, the suggestion in 1993 that preceptorship might offer a partial answer to the demographic problems of recruitment and retention was seen as rather a naive and altruistic one. Any difficulties encountered as part of this study (as already discussed in detail in earlier chapters of this thesis) has in retrospect then been a reasonably fair exchange if, as is hoped, the model of preceptorship that has evolved can be disseminated and used more widely as an incentive to provide better emotional support and more sensitive educational practice in response to the needs of newly qualified or returning nurses to the workforce in this time of need and perceived crisis in nursing's development.

Equally well, those agencies which participated in the research may claim credit for having the foresight to invest in research which might ultimately prove useful for economic and strategic purposes although this was far from guaranteed at the beginning of the study.

Practice as the Link between Theory and Method

Ridley *et al* have called for more research to try and determine whether and when nursing students' perceptions of personal and professional power are established in nursing learning environments [sic]. In their own study of pre-registration preceptorship in the United States, preceptor support was apparently not successful in producing nurses who felt able to influence and lead others in practice (Ridley, Spence Laschinger & Goldenberg, 1995).

In comparison with the present study it is possible to attribute this to the student/instructor dyad in North American models of preceptorship. The US model does not offer support on the basis of a relationship with equals, i.e. with both practitioners being accountable for practice; so that a perceived imbalance of power in the support relationship may have an inadvertently disabling influence on students which may in part account for preceptees' continued feelings of helplessness. The introduction of preceptorship to pre-registration nursing education here in the UK (as described in Figure 1 above) may therefore be open to the same fundamental weakness, unless it is possible to recognise the centrality of practice to theory development as part of the teaching and learning evaluation. The discussion on preceptors as 'judge and jury' in performance evaluation as discussed in Chapter 6 is also an important factor for consideration.

In the primary researcher's view the outcomes of these two studies demonstrates clearly that practice provides the vital link when trying to integrate theory and method. The perception that 'practice' is but the poor relation of theory is still a major disincentive in both theory production and the ability of practitioners to gain satisfaction from "theories -in-use". Eraut has attributed the apparent divide between theory and practice as the failure to "properly recognise theory-in-use" (as emphasised by Argyris & Schon, 1974):

"The process of interpreting and personalizing theory and integrating it into conceptual frameworks that are themselves partly inconsistent and partly tacit is as yet only minimally understood"

(Eraut:1994:157)

The greatest achievement of action research (as exemplified in this study) is therefore the extent to which deriving theory directly from practice enables the interpretation and personalization of theory to be made explicit and relevant to practitioners. At the same time theory is not demoted, but rather practice is elevated to a level of parity with and integral to conceptions of theory, thus recognizing the tremendous potential for improvements in critical thinking and critical practice through the spirit and method of reflective inquiry.

Action Research as a Vehicle for Reflection and Learning

Somekh (1995) writes that action research succeeds where other methods of social science have failed because it manages to bring about actual improvements in practice.

By rejecting the concept of a two-stage process in which research is carried out first by researchers and then applied by practitioners, Somekh believes it is possible to successfully integrate the two processes of research and action. Those researchers who may not be full-time practitioners in the same sphere as those involved in the research can still play a vital facilitatory role in becoming "critical friends" in the change process.

However, action research has also been criticised as a type of "superstructural social engineering" which is in some ways too vague and perhaps dangerously seductive to researchers who too readily accept extravagant claims as to its usefulness:

"The seduction lies in its promissory character - that it is the only kind of research that will 'get results' or make a real difference....[It is] not simply about testing research in action to see if it works according to the prescriptions of formal theory...neither is it concerned merely with informed procedure or the appropriateness of techniques of inquiry to support social action" (Usher & Bryant, 1989:116/7)

These authors attempt to deconstruct the term action research, arguing that with its emphasis on diagnosis and innovation, action research's real potency lies in its potential to offer opportunities to staff "to be identified with 'initiatives' of an apparently dynamic kind" (ibid:118). This seems to infer, however, that such opportunities are likely to be more cosmetic than real, with practitioners cynically adopting the stance of token researchers rather than change agents in the action research process.

Not all authors are of the same view, however, with Nolan & Grant, for example, lauding action research as an appropriate mechanism for "agreeing basic values as a precursor to change" (Nolan & Grant, 1993:305).

This alone could be said to be a valid use of the method, with practitioners being encouraged to clarify values ahead of any proposed innovation. It was this quality of action research which initially attracted the interest of the primary researcher, particularly as it challenged the traditional notion (described by Porter, 1993:137) of "naive realism, the philosophy which animates much nursing research, and which leads researchers to assume that attainment of objective knowledge is possible". Porter believes that in order to be authentic nurses should first accept that they are part of the social situations which they study. By recognizing human subjectivity and attempting to understand the effects of the researcher/s, it is possible to be more reflexive in outlook (Porter, 1993).

Carr and Kemmis, well known exponents of the action research method in mainstream education, argue that the challenge for contemporary educationalists is that of "*acting educationally* in social situations which typically involve competing values and complex interactions between different people who are acting on different understandings of their common situations". Action research in their view is a social process concerned with improving educational practices [and therefore learning] based on the presumption that "truth and action are socially-constructed and historically embedded". Unlike strictly interpretivist researchers, action researchers are deliberately activist and 'subjectivist' in that they emphasize the subjective understanding of the actor as a basis for interpreting social reality (Carr & Kemmis, 1986:180). They describe this as a "dialectical view of rationality" because it helps people to distinguish between what they can and cannot change through the dialectic of thought and action (ibid:184).

It is perhaps necessary to bear in mind that action research is no magic formula for resolving all of society's ills. Having survived being part of an action research project it is possible for co-researchers to imagine the effects of such a project had it adopted a more coercive or sinister stance. Action research is therefore no better than any other method for protecting the researched from the undemocratic or unethical practices of unenlightened or otherwise dictatorial employers/government agencies. An awareness and sensitivity to the needs of participants is not a 'given' in action research, however it may be 'marketed' to potential participants, so that absence of any clarification of values and expectations may be viewed with suspicion by action researchers with a social conscience. Action research may equally be used as a form of social coercion through which participants may 'learn' uncritically, thus running the risk alluded to in Chapter Two of unwittingly (or wittingly) educating to oppress.

"Good action research" has been described as that which "is determined by the degree to which the research is useful in solving practical problems and contributing to a general knowledge of organizations" (Barton Cunningham, 1993:61). This criteria does not, however, account for the impact of the research on the ability of individuals to use the method as a personally reflective and educative exercise. As Schratz and Walker remind us:

"We cannot understand who we are except through social action, and we cannot engage in such action without inviting change. None of us is an island entire..."

(Schratz & Walker, 1995:137/8)

As far as *becoming* a researcher is concerned, we are initially involved in "learning to conform to the rules, customs and traditions in our chosen fields".

When it comes to actually doing research, however:

"We learn, sooner or later, that we have to break free of these same conventions if we are able to say anything that will bring about change" (ibid: 138).

As such, then, participation in action research is an emotionally laden enterprise. In changing the world, in however small a way the researcher/s is also changed. Were they not, then the processes of critical reflection and learning as described earlier in this thesis could not be said to have taken place.

Interpretive activity exposes the conceptual structures and pragmatic working theories that people may use to explain their conduct (Stringer, 1996:81). As an interpretive process, action research helps to keep group members informed and knowledgeable about their subject, allowing them to contribute their own creative ideas (Stoter, 1997:105). What it also does, however, is lay bare the mistakes, misunderstandings and groundless assumptions which inform the actions of participants, leading to painful episodes of self-reflection and learning which have to be recognised and properly accounted for.

This brings us to a consideration of the impact of action research on the person who instigates the study, and a questioning of the rationales and assumptions of that person in deciding that the subject is researchable and a worthwhile area of study. The key to understanding the position of the primary researcher in this case is again in understanding the different power relations which may be said to influence individual 'stakes' in the project.

The idea of the psychological contract implicit in the research process can again be a helpful way of unravelling this process and suggesting ways in which reflection and learning resulted from involvement in the research itself. Implicit in the notion of contract is the idea of 'fair exchange'. One of the most notable insights afforded by this research (for the primary researcher personally) has been the reflexive nature of the preceptorship support paradox to the primary researcher herself.

Experiences (both good and bad) as a nursing student and as a newly qualified member of staff were without doubt a very strong influence on the primary researcher for instigating the study. Similar experiences as a trainee and then newly qualified journalist had led to an acute awareness of the personal, emotional (and sometimes physical) risks taken by newcomers as they straddled the 'status passage' required to become an accepted member of their chosen occupational group. Anecdotal experience of beginning practice led the primary researcher to question the rationale of such practices and to want to better understand the reasons (both espoused and 'hidden') for continuing to depend on ad hoc learning situations and often ambivalent (if not openly antagonistic) relationships for communicating the values and characteristics of the work to be undertaken. This seemed to be a very laissez-faire approach to workplace learning which might be better understood from closer study and examination of the phenomenon of socialisation and support with a critical eye.

The primary researcher also entered into the study hoping to uncover existing alternatives to the practices which had been evident in her own experience. In illuminating the status passage of nurses, however, a further personal revelation awaited her, which is the status passage of the research student in becoming an accepted and valued member of the academic 'community'.

Again faced with the phenomenon of 'reality shock' as a beginning academic employed within a major university, the primary researcher was startled by the similarity of approach by colleagues as to the initiation processes required to become a *bona fide* researcher, at least in the eyes of colleagues in academia. Although this constitutes what can only be seen as a personal *post-script* to the present study, it is nevertheless revealing in that the same dependence on rite and ritual is evident in the initiation of newcomers to academia as it was in the settings used for the study of nursing. The irony thus arose that in attempting to better understand and improve the lot of nurses, the primary researcher exposed herself to an inadequate social support network within the institution of a university.

In examining ethical support initiatives, who or what existed to support the primary researcher in her own transition to contract researcher? Who, or what existed within this 'institution of learning' to help encourage or instil the moral virtues of a "good" academic life in the newcomer? While some support could come from the research supervisor and fellow students from her alma mater, family and friends, the answer from the employing institutions's point of view was, "sadly, very little". The psychological contract was again open to construction, and no real attempt was being made by employers to formally recognise the need for social support in the new employee.

The social constructions of academics and the research community would no doubt prove a fascinating subject for description and analysis, and, alas, therefore only a passing mention may be made of it here in the context of the primary researcher's own use of action research as a vehicle for *personal* reflection and learning.

In conclusion, then, action research has both the potential to change the world but also to alter perspectives on the "right way to live". Few researchers, having embarked on an intensive study such as this, could be prepared fully for the revelations (personal or collective) which can emerge to challenge the status quo. For Fukuyama, a lack of belonging and the continuing pursuit of it, is representative of what he sees as a late 20th century social phenomenon, namely what he describes as "a crisis of trust" (Fukuyama, 1995:269).

If as educators we are to encourage 'teaching as care', so that as Plato advised "those having torches will pass them on to others" (Dalo, 1986:236) we will have to be sensitive and proactive in seeing that in future what we espouse as educators is also what we *do*. Then, and only then, will we achieve the dialectical relationship of human value to which Socrates in his wisdom so famously aspired.

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Appendix

Selected Documentation

Unit Preceptor Selection Criteria

In order to be considered for acceptance onto the UNIT PRECEPTOR preparation programme individuals must be registered first level practitioners and:

1. have undertaken a recognised course in the teaching and assessment of staff in the clinical area, and have at least six months experience as a qualified assessor of student and trained nursing staff;
2. have an understanding of the philosophy and rationale for care in the unit to which they are to be allocated. Units should consist of no more than a complement of 12 designated preceptors at one time;
3. be familiar with the employing institution, its approaches to staff development and its nursing staff recruitment and retention policies;
4. have at least two years experience in the assessment, planning, implementation and evaluation of care in an area included in or closely related to that of the setting to which they are to be allocated;
5. have attended a formal briefing regarding the aims and curricular outlines of the proposed preceptor programme;
6. have empathy and regard for the stated aims of that programme;
7. have a willingness to undertake formal preparation for the role of Unit Preceptor, on the understanding that there is no guarantee of acceptance onto the programme at the end of that preparation;
8. have an up to date personal, professional profile which may form the basis for their development and practice as Unit Preceptors.

Designated Preceptor Selection Criteria

In order to be considered for acceptance onto the DESIGNATED PRECEPTOR preparation programme individuals must be registered first level practitioners and:

1. have experience in the supervision of trained and untrained staff in clinical practice;
2. have an understanding of the philosophy and rationale for care in the clinical area to which their prospective preceptees are to be allocated;
3. be familiar with the employing institution, its approaches to staff development and its staff recruitment and retention policies;
4. have a working knowledge of the curricula and outcomes of the pre-registration programmes undertaken by their prospective preceptees;
5. have at least twelve months experience in the assessment, planning, implementation and evaluation of care in the setting to which their prospective preceptees are to be allocated;
6. have attended a formal briefing regarding the aims and curricular outlines of the preceptor programme;
7. have empathy and regard for the stated aims of that programme;
8. have a willingness to undertake formal preparation for the preceptor role, on the understanding that there is no guarantee of acceptance onto the programme at the end of this preparation;
9. have an up to date personal, professional profile which may form the basis for their development and practice as designated preceptors.

PHILOSOPHY OF PRECEPTORSHIP

It is our belief that every newly registered nurse and those returning to practice will benefit from a period of support with a preceptor. This will facilitate a smoother role transition and assist in clinical socialisation. We will endeavour to provide such a support system on each ward/department within the hospital.

The definition of preceptorship we have chosen to use is that of Morton-Cooper A. 1993.

"A QUALIFIED AND EXPERIENCED FIRST LEVEL NURSE WHO HAS AGREED TO WORK IN PARTNERSHIP WITH A (NEWLY) REGISTERED PRACTITIONER COLLEAGUE IN ORDER TO ASSIST AND SUPPORT THEM IN THE PROCESS OF LEARNING AND ADAPTION TO HIS OR HER ROLE".

The preceptorship pairs will work together for a period of not more than four months. Within this partnership there will be a structured learning process which will take the form of a contract of learning, critical incidence analysis and diary keeping. Reflective learning will be encouraged. Learning outcomes will be negotiated and reviewed regularly with dates set in advance.

Each individual partnership will set their own boundaries for the relationship, negotiate needs and form learning contracts based on those needs.

We acknowledge that, due to the nature of our work, good time management is essential if we are to achieve set learning outcomes in a short space of time.

At all times we will strive to be good professional role models, friends on the wards/departments and offer support.

We will remain aware of the pre-registration curriculum and base our practice on sound research, sharing our knowledge with our colleagues in preceptorship.

Preceptorship Learning Contract

Preceptorship Project

LEARNING CONTRACT

Name of Preceptor:

Name of Preceptee:

Date Preceptee Appointed:

Role/Grade of post held:

Main function of post:

Period of Learning Contract:

1. Learning Intentions

2. Learning/support needs identified:

3. Ways in which new learning is to be achieved

4. Modes of feedback/progress reviews:

5. Overall Evaluation and Future Plans:

Signed:

Manager's Comments:

Signed:

Unit Preceptor:

PRECEPTORSHIP RECORD

1 Learning Intentions

2 Learning/support needs

3 Ways in which the above are to be achieved

4 Modes of feedback/progress review

5 Evaluation and future plans

Request for interim evaluation:

*** Diaries completed (not less than weekly)**

*** Dates set for review meetings: (not less than one month)**